EXPANDING THE CIRCLE

A Community Approach to Children's Mental Health

Gerry Fewster

CHILDREN'S MENTAL HEALTH PROJECT

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This document is about children's mental health. It is about the growing number of young people in our communities who, for one reason or another, are unable to come to terms with themselves and the worlds in which they live. It is about the caregivers who struggle with their own life experiences while coming to terms with the responsibilities of parenting. It is about the professionals who care enough to acquire the knowledge, resources and skills to 'be there' when the going gets tough. Finally, it is about the planners and administrators who know that somewhere there is a better way.

G.D.F.

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Alberta Children's Mental Health Project
Department of Social Services and Community Health

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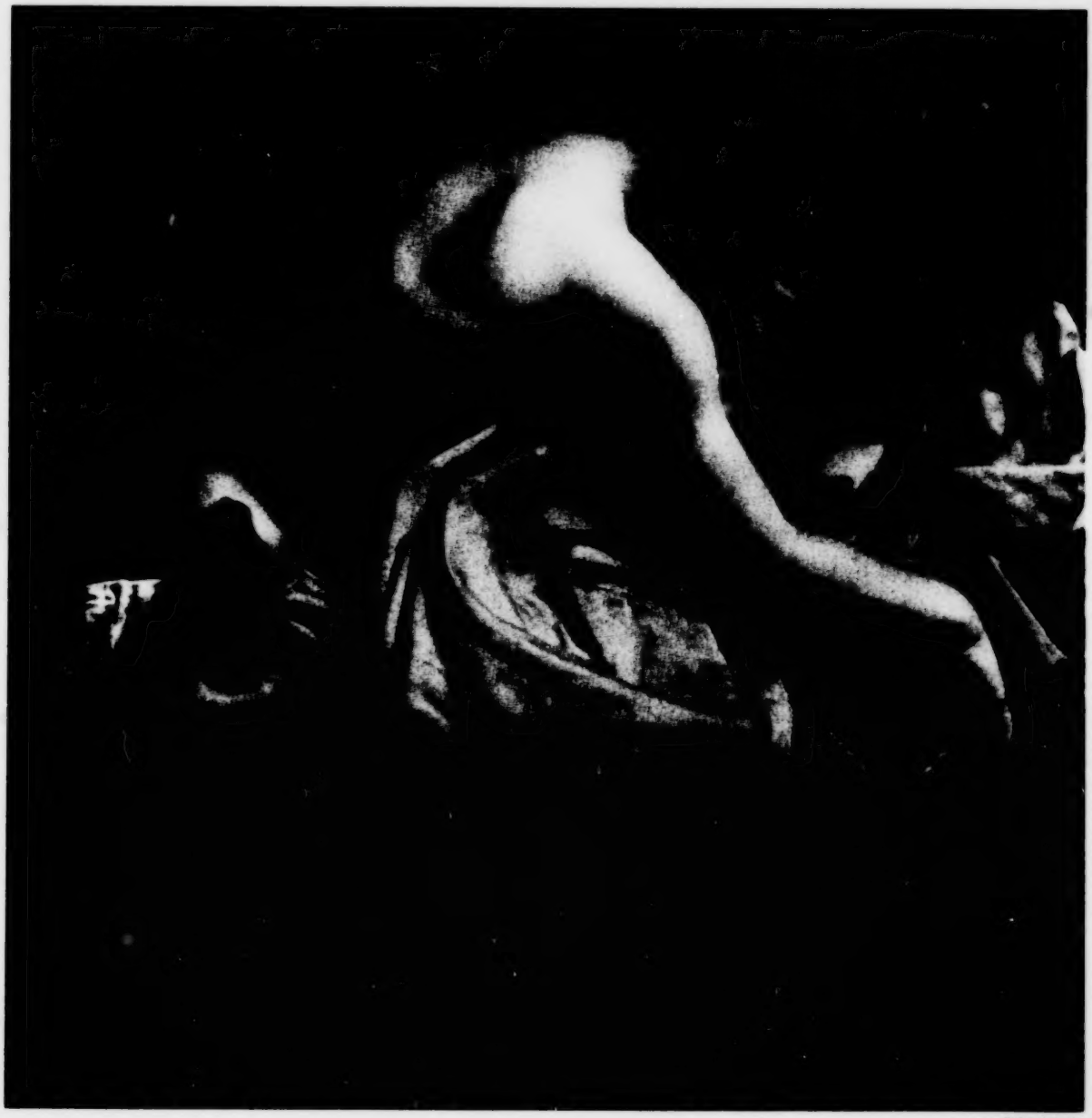

Arthur Leipzig

Feel the dignity of a child. Do not feel superior to him, for you are not.

Robert Henri.

ACKNOWLEDGEMENTS

This document emerges from the Alberta Children's Mental Health Project of the Department of Social Services and Community Health. More specifically it reflects the work of the Core Team established in the Fall of 1985 to focus children's mental health issues and develop a strategic plan for departmental initiatives in this area. Although authorship of this particular paper rests with the Project Manager, the content reflects many hours of discussion and consideration on the part of all team members. While the author accepts full responsibility for the outcome, the document also belongs to all who served as members of the team. They were: Murray Armstrong, Norma Elbe, Joan Martin, Dean Melsness, Brian Parker, Francie Rauch and Roberta McKeen. The team also received ongoing consultation and support from Catarina Versaevel and Denny Barr. In addition, expert analyses and advice were provided by Gus Thompson, Bernd Walter and Alf Nobert.

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PREFACE

In November 1985, the Children's Mental Health Project of the Alberta Department of Social Services and Community Health published a discussion paper entitled *Service Philosophy, Principles and Guidelines*. This document was intended to offer suggestions as to how the Department might begin to develop an integrated system of mental health services for children and families in conjunction with other major departments and jurisdictions. The paper was distributed to provincial and regional groups involved in the planning and delivery of children's mental health services for the purposes of discussion and consultation.

In the discussions that followed, the complexities of the task became increasingly apparent. Jurisdictional, departmental and regional boundaries, differential mandates and glaringly disparate opinions on mental health issues made discussion difficult and systematic planning virtually impossible. It was clear that the establishment of a Provincial design for children's mental health services would require a collaborative effort at the highest possible inter-departmental level of government as well as effective co-ordination within all regions and communities.

Short of this ideal, it would have been possible for the Children's Mental Health Project to take an expedient stance by recommending a set of departmental initiatives designed to improve existing services within the context of an extended mandate. Rather than repeat the perennial exhortation for more services and resources, however, it was decided that the mental health of young Albertans should be viewed as a Provincial concern and that the issue should be addressed not only by those involved in the delivery of services but by concerned individuals and groups in all sectors of the community.

The purpose of this present document is to promote such discussion. While many of the most salient issues are identified, it does not purport to provide a comprehensive analysis of all possible approaches to children's mental health. The observations and conclusions are undeniably idiosyncratic, reflecting the particular beliefs and experiences of the author in collaboration with members of the Children's Mental Health Project Core Team. Since it is presented as a discussion text rather than a proposal brief, readers are encouraged to disagree with the content in forming their own conclusions about what mental health means and how it should be translated into community action. Hopefully, a commonality of commitment to the emotional and psychological wellbeing of young people in Alberta will, at some point, transcend the polemics of the debate.

In the most general terms, the position presented in this document is that a children's mental health service should be delivered within a broader framework that actively promotes the mental health of all children through families, schools and communities. It suggests that this responsibility ultimately belongs to the communities and not to the professionals who serve them. It promotes prevention as a fundamental thrust, rather than a token after-thought and rejects the notion that children should be treated as miniature adults. Finally, it proposes that needs and services should be identified through consumer and community initiatives rather than through expert enlightenment. Such propositions do not generally fit well with traditional mental health practices. On the other hand, traditional mental health practices are not beyond challenge.

It is not the intention of this document to inhibit, or arrest, existing regional planning in the area of children's mental health service delivery. On the contrary, it is to be hoped that any discussions generated by this submission will contribute, either directly or indirectly, to the planning process.

July 7, 1986. Gerry Fewster.

James Jaen

To be made a patient is to be remade into a serviceable object. the irony being that so little service is available once this is done.

Erving Goffman.

PART I
CHILDREN'S MENTAL HEALTH SERVICES:

THE ELUSIVE MANDATE

INTRODUCTION

In Canada and the United States, mental health services for children and adolescents are usually provided by agencies that also serve adult populations (Doherty, 1985; Meyers, 1985). It is clear from the data generated by these agencies that a very small proportion of available resources is actually directed toward the needs of young people. In the United States, it has been estimated that over two thirds of the children and adolescents exhibiting severe emotional difficulties have no access to appropriate services (Knitzer, 1984). With budgets becoming tighter over the past few years, the situation has continued to deteriorate and an increasing number of observers have been calling for a renewed commitment to children's mental health (Shore and Mannino, 1976; Behar, 1985).

In our view, a children's mental health service must begin with a clear legal and operational mandate that directs resources and coordinates service delivery. We take the position that communities should be supported in their efforts to attend to the developmental needs of children and that a coordinated mental health service is a necessary condition of such a commitment. Within the broader framework of mental health, we consider a system of children's mental health services to be the foundation of preventative action.

The formula for developing a children's mental health system is remarkably simple:

1. Define the arena and identify the problems;
2. Identify the needs;
3. Determine the strategies most likely to meet the needs;
4. Specify and acquire the resources necessary to implement the strategies;
5. Mobilize the resources in the most effective, efficient and accountable manner;
6. Ensure that new services and structures are coordinated with existing services and systems;
7. Establish methods for evaluating service effects and changing needs and determine the means through which services will be modified in the light of changing needs;
8. (Take a bow).

1. DEFINING THE ARENA OF CHILDREN'S SERVICES

Service Delivery Issues

We begin with the assumption that children's services should be considered in their own right. Children are not miniature adults. In our society, they are given sixteen years to learn the ropes. Meanwhile, children are the responsibility of parents or surrogates who, having passed the chronological test of adulthood, are expected to demonstrate the necessary competence and commitment to nurture, teach and protect throughout the developmental process. It is hardly surprising that, sometimes, things go wrong. In these instances, we call upon the experts.

The first task is to determine what went wrong. In mental health, this may be referred to as "assessment" or "diagnosis". Secondly, some form of remedial action must be designed and implemented. This may be called 'intervention' or 'treatment'. Finally, the results of this action should be tested out and evaluated. Clearly, there is nothing wrong with the logic inherent in this approach. In practice it has become the cornerstone of our technological world. In the development of social and psychological services, however, the track record is less than spectacular.

From the outset, we seem to have monumental difficulties in locating the problem to be addressed. Mental health problems associated with children and adolescents have been attributed to poverty, cultural deprivation, family conflict, parental pathology, school failure, early trauma, developmental delay, brain dysfunction, biogenetic influences, faulty learning, etc., etc. In any given case, the possibilities appear endless and it may well be that the problem is more likely to be identified in terms of the interests and beliefs of the expert rather than the subjective experiences of the 'client'. Given the collective experience of the helping professions, it seems reasonable to conclude that the life of a child or adult cannot be represented as a complex array of independent systems that adhere to cause and effect principles. Perhaps we make more 'choices' than we care to acknowledge.

With children and adolescents, the issue of intervention through service provisions creates particular difficulties. Even where it is determined that the problem is to be located *within* the child, ultimate responsibility still rests with the caregiving adult or adults. In many situations, a child may not even seek such services on her or his own behalf, regardless of the degree of distress experienced. By the same token, professionals who take it upon themselves to become involved without parental support and consent risk censure and even legal action. The reaction to this type of 'interference' is very understandable since such actions may effectively undermine the responsibility of the parent or surrogate, to say nothing of the potential for stigma, shame or 'loss of face'. The opposite, and potentially more tragic, side of this coin appears where parents come to believe that they are incompetent in understanding or dealing with the problem. One of the most depressing aspects of children's services is the number of parents and families who have simply given up in the face of, what appear to be, insurmountable odds. In this context, the more the expert is seen to be needed, the more incompetent the parent may become. As the responsibility shifts from caregiver to professional, the risk to all parties, including the child, increases.

Evaluating the effects of children's services upon the children themselves is no simple matter. Even the most intensive form of intervention does not occur in a vacuum. Generally speaking, children are particularly sensitive to their worlds, since much of the information they receive has not been incorporated into well established beliefs or attitudes. Hence they may be influenced by a vast array of interactions and events far beyond the scope of the intervention procedure. Additionally, children are caught up within the struggles and insights of their own developmental experiences.

resulting in many outcomes that are relatively independent of environmental or interpersonal influences. It is also possible that many so called intervention effects may not be apparent until many years after the intervention itself. It will always be difficult, therefore, to conclude that a particular service has been successful in bringing about a particular outcome. Furthermore, as all seasoned clinicians and child care workers know, intervention seems to be associated with many effects that were not anticipated, or even apparent, at the time of evaluation. Even children make choices.

The purpose of the above discussion is not to suggest that governments and communities should not provide social or psychological services for children and their families. Program planners and practitioners should, however, proceed with caution and a sense of humility. The growth and development of a child within the contexts of the family and community is a complex ecological phenomenon and, wherever possible, energy and resources should be directed toward supporting the natural order of this ecological system. Where intervention is requested, or deemed necessary, it should be based upon the experience of the client rather than the values and beliefs of the practitioner. Specialized services that focus upon a restricted area of knowledge and expertise should, as much as possible, be understood by the service recipient and carefully integrated into the experiences of everyday life. In delivering children's services we should, then, be concerned with the subjective experiences of at least two people, i.e. the child and the caretaker. Their understanding and participation is essential.

In summary, we find ourselves in general support of the popularized concepts of 'normalization', 'minimal intervention' and 'community-focused service provision'. We do not believe, however, that it is sufficient to simply develop service systems around such notions. Even within a system that effectively integrates services, it is still possible to separate the child from the family, thinking from feeling, behavior from understanding and learning from experiencing.

By far the more critical issue is one of attitude. As service providers, we cannot allow ourselves to become the moral guardians of the society or the individuals we seek to serve. Providing a service begins with listening to the wishes, hopes and aspirations of the client. Even where we need to step in for the protection of the adult or child, the ultimate objective should be one of assisting each individual to move toward her or his own personal sense of destiny. Finally, we must allow individuals to choose their own particular pathway, holding ourselves responsible for the integrity of our contribution, but not for the actual choices made by the service user. In this regard, we would consider the child to be a 'client'.

The Issue of Mental Health

> "Wise men see outlines and therefore they draw them.
> Mad men see outlines and therefore they draw them".
>
> William Blake.

In its broadest and most literal sense, mental health refers to an overall condition of the 'mind'. From this perspective, it is difficult to imagine any human action or experience that is not somehow related to the perceiving, thinking and feeling side of human nature. Even the most habitual acts and routine experiences have the potential of producing thought and reflection. Hence, it is possible to justify a mental health service that addresses all aspects of the human condition. To do otherwise would only serve to remove the mind from the world of everyday experience . . . an unthinkable, if not unhealthy, prospect.

On the other hand, it is unreasonable to expect any individual, or group to be all things to all people. Hence, we must narrow down the scope and generate systems that make the most effective use of limited resources by focusing our activities. Hopefully, we can continue to appreciate that the divisions we create are of our own making and not representative of life itself.

Limiting the scope of mental health through definition is no simple matter, however. In everyday usage, mental health refers primarily to a subjectively experienced state of emotional and psychological well-being. In this sense, it embraces the individual's personal feelings of autonomy, competency, spirituality, esteem, etc. In defining mental health, professionals generally prefer a more 'objective' approach, based upon the individual's presentation to the world. From this perspective, behavior (including verbal behavior) provides the necessary clues from which inferences about inner processes might be made. In this context, it is the perspective of the practitioner, rather than the client, that matters.

Unfortunately, neither perspective provides us with a solid operational definition of mental health. The subjective experience is usually expressed in terms of feelings while the more objective view is concerned with symptomology and, thereby, mental ill-health. Reconciling these different and, at times, competing realities may be impossible since they emerge from very different arenas of experience and knowledge. Neither represents the 'truth' in any absolute sense.

In spite of the difficulties involved, however, a system of mental health services for children and families still requires some definitional base from which to establish an effective mandate. In our opinion, primacy should be given to a concept of mental health that stresses the individual's sense of emotional and psychological well-being within the context of society. The broadest objective of a mental health service, thereby, becomes one of identifying the conditions that make such experiences possible while promoting these principles with individuals, families and communities. The so called objective view becomes more significant when a problem arises and the opinion of the professional is requested, or deemed necessary. In accordance with the broader mandate, this should occur as early as possible in the development of the identified problem.

Since we have chosen to define mental health in terms of the subjective experiences of the individual, any direct intervention on the part of the practitioner should respect the private world of the individual by being as unintrusive as possible. However effective a particular service might be, we recognize that there will always be instances where the individual becomes so personally and socially disruptive that highly restrictive and intrusive measures will need to be taken. This does not mean that the subjective definition of mental health should be abandoned at this point, however. To simply objectify the individual in terms of a particular category or classification in order to justify the intervention, is to resort to a totally different definitional base and sense of purpose for service delivery.

Toward a Children's Mental Health Service Mandate

In this section, we have moved cautiously and tentatively toward developing a mandate for a children's mental health service. Obviously, we have not gone far enough. As yet, we have made no clear distinction between children's mental health services and child welfare, family support, services for the handicapped, education, corrections, etc., since all are concerned with the personal well-being of individual children and adolescents. We have also complicated the task further by suggesting that service divisions are arbitrary and may present a fragmented view of individuals,

families and communities. Finally, since we have no objective operationalized concept of mental health, we have no clearly defined standard from which to generate a useful statement of mission or purpose.

In distinguishing mental health from other related services, many commentators have suggested that something called "treatment" be the exclusive property of mental health practitioners. Hopefully, they have a much more acceptable definition of this concept than we have been able to draw from our reviews of the literature. In our experience, treatment is often defined in terms of other equally ambiguous concepts such as "psychotherapy" or "strategic intervention". In many cases, we have found that the term treatment refers more to the orientation and qualifications of the practitioner than the nature of the practice. Nowhere have we found a definition that would clearly distinguish one set of service provisions from another in an acceptable way. In response to this apparent confusion, we have opted for a functional definition of treatment that we do believe to be the exclusive domain of a mental health service. In this context, treatment refers to a process in which:

1. The psychological needs of individuals are assessed and identified by professionals duly qualified to conduct such assessments.
2. Specific intervention or remedial strategies, based upon such assessments, are designed and implemented.
3. The process is monitored and evaluated in terms of the psychological well-being of the individual.

In our submission, where any or all of the above apply, practitioners should be involved in a system that offers both support and accountability, i.e. a mental health system. By the same token, recipients of the service have the right to know that such treatment is provided to the highest possible standards and that practitioners are supervised by appropriately qualified personnel.

In broadening the scope of the treatment mandate, we believe that society cannot continue to pour its limited mental health resources into the bottomless pit of crisis intervention while ignoring the habits, life styles, attitudes and practices that continue to promote psychological distress for individuals within families, schools and communities. A children's mental health service should, therefore, have a clear mandate to work along side other professionals in promoting the concepts of mental health, developing and implementing strategies of prevention and, wherever possible, pursuing a pathway of early intervention. In these areas, the demarkation lines of service provisions become less clear but, in our view, such ambiguity can be readily justified in developing a holistic approach toward the psychological or mental health needs of children and families.

Thus far we have failed to develop a standard for community mental health that might serve to give direction to a children's mental health service. Part of the difficulty stems from the fact that we have stressed the importance of personal subjective experience as the central point of reference for the identification and resolution of needs. This does not mean that such a service should be lacking in goals and objectives, however. On the preventative side, we would suggest that services be directed toward assisting individual families and communities in addressing their own mental health issues. This would involve establishing a network of educational, training and consultative services accessible to the community at large. Given the special needs of children, such services should be directed toward providing support for community based caregivers, such as parents, teachers, youth leaders, child care workers and the like. This supportive role should also be maintained where direct intervention is deemed to be necessary. In this

case, we believe that the individual child's existing relationships and support systems, particularly within the family, should be mobilized as an integral part of the treatment process. Even where individual treatment is provided directly to the child or adolescent, the social context should continue to be a significant point of reference. This calls for a wide range of differential treatment services that can be accessed readily and imposed rarely. In this sense, the term 'differential' means that services should be tailored to the individual needs of children and their families and that such services should not be isolated and separated from one another. Even where the most intensive forms of intervention are deemed necessary, the ultimate objective should be one of encouraging each individual client to assume personal responsibility for her or his own state of psychological and emotional well-being.

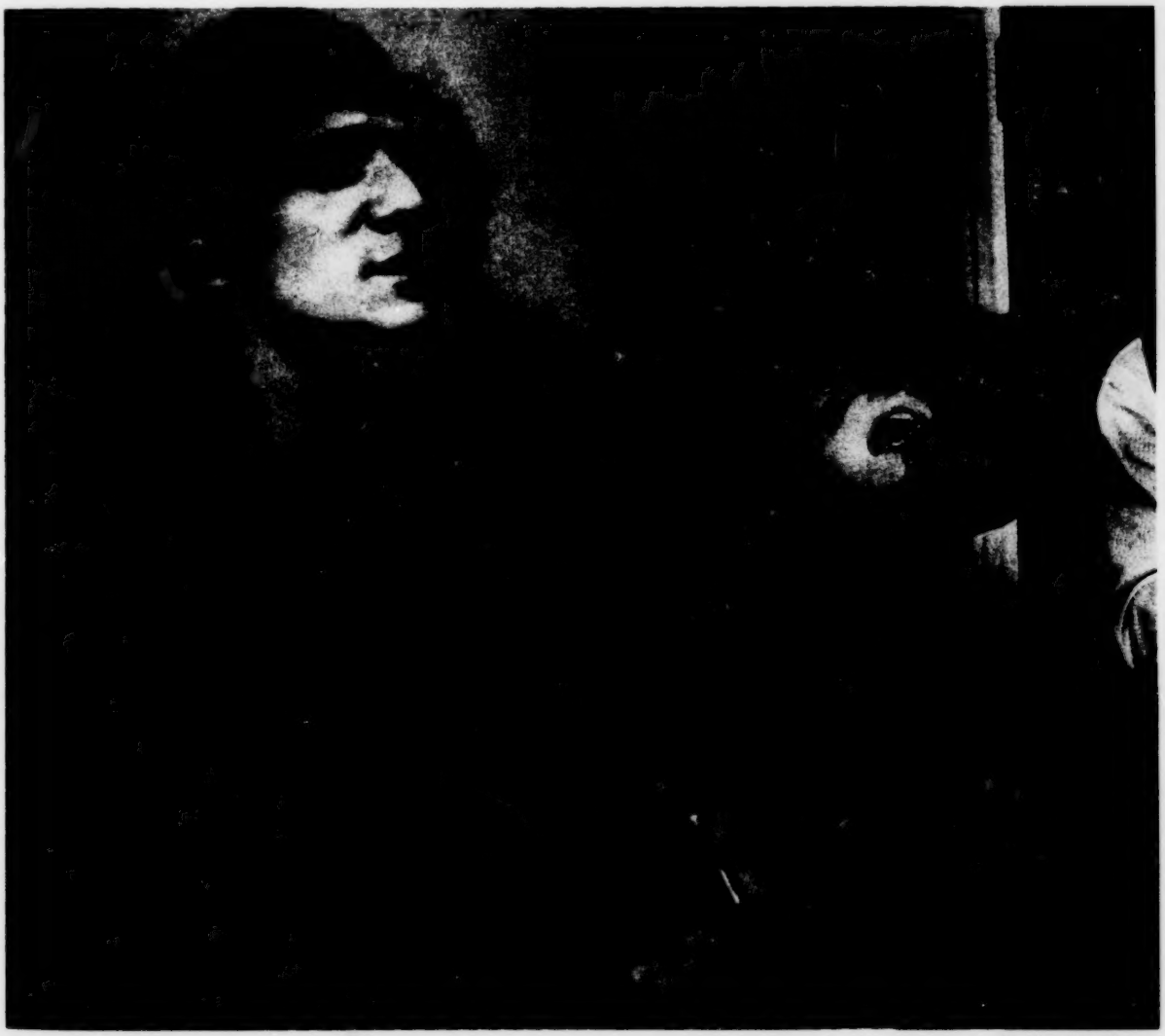
In the final analysis, we are still left with the problem of determining what a children's mental health services system might hope to achieve in order to fulfill its mandate. We need to define our expectations in clear, and preferably measurable, terms. While many of these expectations may emerge from the specific needs identified by the service community, the preceding discussion implies a number of general values that might be expressed as broad standards for a children's mental health service within any given community. These standards would then be used as a framework for need identification. For example:

1. Every young person should have caregivers who understand her/his unique emotional and psychological needs for security, esteem, competency and autonomy.
2. Every young person should have social and emotional support in the exploration and development of the self.
3. Every young person should learn and appreciate societal rules and cultural values.
4. Every young person should be protected from individuals and circumstances damaging to her/his psychological or emotional well-being.
5. Every young person should have support and assistance from caring and knowledgeable adults at times of psychological or emotional distress.
6. Every young person should assume personal responsibility for personal actions.
7. Every young person should be able to modify her/his own behavior to meet changing circumstances and conditions.
8. Every young person should understand and respect the needs and wishes of others.
9. Every young person should be able to communicate her/his needs to others.
10. Every young person should be able to pursue her/his own potential and sense of personal destiny.

Of course the above list is arbitrary; the statements are not operationalized to facilitate measurement; they may not be universally acceptable; they are not necessarily comprehensive. On the other hand, if these standards could be attained through a mental health service, we would have something to cheer about. In other words, they represent no more than a point of departure for the development of a mental health service; a means whereby general standards might be developed to some point of consensus. They are not 'clinical' in nature since, from this perspective, clinical goals and practices are seen more to be a means to such ends.

In summary, we are proposing a children's mental health service that cannot be contained within the traditional parameters of a last ditch attempt to treat the most emotionally and psychologically crippled young people in our communities. We are suggesting that mental health professionals should be invited to step off the perpetual curative tread

mill and move directly into the communities by integrating their services with others who seek to enhance the overall quality of life for children and those adults who assume caregiving responsibilities.



Mary Ellen Mark/Magnum

What is that to him that reaps not harvest of his youthful joys
Tho' the deep heart of existance beat for ever like a boys.
Tennyson

2. THE IDENTIFICATION OF NEEDS

Asking the Right Questions

It is now widely accepted that all planning for social and health services should be based upon some form of systematic Needs Assessment. Essentially there are three reasons given for conducting such assessments, i.e. (1) to address the goal of client satisfaction; (2) to ensure that monies are expended in an accountable fashion; (3) to establish priorities in the allocation of scarce resources.

In the area of mental health services, the predominant trend has been to replicate the medical approach with epidemiological surveys that attempt to estimate the prevalence of mental disorders or disturbances. From these data we find that over three million children in the United States have severe emotional disorders and that over two million of these youngsters do not receive appropriate services (Knitzer, 1984). In Canada, the Commission on Emotional and Learning Disorders in Children (Celdic, 1969) identified over one million children with similar 'afflictions'. Current estimates from across the continent suggest that between fifteen percent and twenty percent of young people below the age of nineteen are, at some point in their tender lives, in need of professional care and treatment (Bland, 1982; Offord et al, 1984; Chamitoff and Byles, 1984).

As Klein (1979) has indicated, however, such survey research is beset with political, financial, professional and methodological limitations. Nevertheless, it represents a useful kick at the cat and, with a commitment to the integrity of social research methodology, it may continue to provide a relevant data base for social planning. The more critical questions to be addressed here, however, are not *how* but *where* and *with whom* such research should be conducted.

Given that we are able to identify needs in the light of some overall set of standards or expectations, it seems reasonable to assume that we should use these standards to determine where we should look for the relevant information. If, for example, we are interested in promoting healthy teeth in a community, we would look to dental records and the profession of dentistry for our Needs Assessment. We would then require some way of gathering information from people who, for whatever reason, ignored the "regular checkup" exhortation. In the field of children's mental health, we have suggested that much of the information on needs is contained within the private subjective worlds of children and caregivers who do not usually present themselves for mental health checkups at regular intervals. Those who do come to the attention of professional practitioners may not be representative of the community as a whole. To complicate the issue still further, children's mental health is not the exclusive domain of any one professional group and the criteria used for assessing problems and needs is rarely standardized.

We cannot reasonably respond to the Needs Assessment issue in children's mental health by simply asking children and caretakers to identify their needs, although this might be a reasonable point of departure. As all social scientists know, such self report data present serious reliability and validity questions and cannot be taken at face value alone. Nevertheless, it is inherent in our statement of standards that we begin with a Consumer Based Needs Assessment. Not only is this the critical area of information but, if we are serious about encouraging individuals and communities to assume increased responsibility for their own mental health, we should go to them first and involve them in the process.

We are not suggesting here that service providers and professional practitioners do not have a critical role in the Needs Assessment process. As with individuals and groups drawn from the community at large, however, we cannot assume the absence of bias, tunnel vision, naivete or vested interest. Again, it is important that these data be

subjected to the rules of scientific enquiry rather than allowing them to be unduly influenced by the persuasive power of particular individuals or groups. In all cases, it is necessary to guard against the 'reactive' nature of such Needs Assessment Research, particularly the tendency for such strategies to increase perceived needs or even create needs that had never been considered before the survey.

By emphasizing a needs-based approach, we are not negating the utility of epidemiological and etiological research. Clearly there are identifiable syndromes or symptom-clusters that reflect particular types of mental health problems and planners should be aware of their distributional and developmental characteristics. Considered alone, however they can create a limited and potentially dangerous reality of sickness and cure that excludes the person from the equation. In our submission this type of information should be carefully considered and translated into a needs-based framework.

Making Use of Needs Assessment Information

The use of 'scientific' methodologies to generate Needs Assessment data is no guarantee that they will be used as a foundation for planning service delivery. In reality, planning decisions are profoundly influenced by political, economic, special interest and systemic factors that are not easily changed in the light of new or standardized information. These influences cannot be simply dismissed as contaminants or distortions since, in many cases, they represent legitimate needs that may or may not have been overlooked in the more formal assessment process. Regardless of their perceived value, however, they will continue to be the primary forces through which scarce human and financial resources are distributed.

The realistic challenge is to develop ways in which Needs Assessment information can be effectively incorporated into the planning process. The first step is to ensure that such information is seen to be relevant, valid and representative by those who are most directly involved in establishing policy, creating the systems, providing the programs and using or receiving the services. It is difficult to imagine how this could be achieved without involving such individuals and groups directly in the assessment process. When it comes to planning, the collaborative strategy might then be extended on the basis of shared information and commonality of purpose. So long as the demands for resources exceed the supply, however, there will never be consensus and those who finally make the decisions will never enjoy the benefits of universal acclaim. On the other hand, policy makers and planners can establish and maintain integrity by developing a planning process that clearly attempts to relate services to identified needs. From our perspective, we might suggest the following formula:

1. Develop a clear policy statement based upon the identified standards. The ten standards presented in the preceding section could be embodied within a formal policy statement without too much difficulty. This would provide not only a statement of purpose but also a framework for the assessment of needs and the identification of priorities. Within the planning process it might be used as a point of departure for consultation with the community and the existing service delivery system.

2. Assess the mental health needs of children against the identified standards. In any given community, this would be no simple matter. Indicators must be established along with appropriate sampling strategies. Many diverse sources of information may be necessary in order to obtain a reasonable overview of the quality of life for children residing in the area. The primary purpose of this exercise would be to identify patterns indicating general areas of need.

3. Assess the potential of community resources to address the identified needs. We have already suggested that, wherever possible, a children's mental health service should attempt to mobilize the resources that make up the everyday life world of the child. Such resources are contained in families, schools, health units, community associations, day care centres etc., etc. It is likely that many of the preventative, or early intervention, strategies could be directed through the caregiving relationships rather than the provision of direct mental health services.

4. Establish criteria for 'special needs'. At this stage, it becomes necessary to identify those children whose needs cannot be met through the more 'normal' social support structures. This, of course, is the group that is most usually associated with mental health services. It is also the group that creates the most problems in terms of articulating the needs and determining the most appropriate services. Without some form of divine intervention, there will be no professional consensus and planners will need to rely upon their own policy statements, values and opinions (hopefully drawn from the community) in making resource and planning decisions. Once criteria have been established, epidemiological and etiological information should be added to the equation.

5. Assess the ability of mental health resources to meet the 'special needs'. At this point, the time has come to evaluate the direct service delivery system. Again, consumers as well as service providers, should be involved in the task of examining the quality and relevance of existing services; identifying gaps and deficits; noting service excesses and duplication; and making recommendations for change. As Offord (1986) has indicated, the "perceived needs" on the part of parents is probably the most powerful determinant of service utilization.

In this process, the competition for resources becomes readily apparent. As advocates and consumers anticipate change and service providers seek to justify their contributions, it is essential that system planners create a climate of collaboration, along with assurances that existing services will not be arbitrarily dismantled. It should be made clear that existing service providers will be given every opportunity to re-direct their energies and resources. Managed appropriately, this analysis should encourage practitioners and agencies to take a broader perspective and increase their participation in coordinating the spectrum of services.

6. Invite service providers to respond. In many ways, individuals and groups involved in direct service delivery are in the best position to determine the changes necessary to meet identified needs. In order to generate solutions, however, they require the support of planning and funding agencies. This may well involve making additional resources available in the short run for agencies to conduct analyses, develop proposals and 'pilot' alternatives. Without this type of support and assistance, those individuals and organizations that are the most committed and capable in addressing client needs will be the least able to respond. Hence, the emerging system may well be based upon a very shaky foundation.

7. Establish mechanisms for on-going needs-services evaluation. Hopefully, a formula such as the one outlined above will create an atmosphere in which service planners and providers can retain their sensitivity and responsiveness to the needs of the community in general and service consumers in particular. To further this end, the system should incorporate a constant flow of information that is readily available to all participants. This shared information base should be related to the initial standards and objectives; the performance of services designed to meet identified needs; and the changing patterns of needs within the particular community. Service planners and providers should *jointly* review these data and frequent consulta-

tions should then provide the basis for ongoing planning and decision making. Particular attention should be paid to the willingness and ability of the community to actually use the services offered (Offord, 1986). In our opinion, this type of approach would do much to diminish the perennial paranoia that characterizes many service delivery systems.

Hugo Muller

Oh, "Kitche Manitou", the Great Spirit, have mercy upon us and our land, that our little children make music for our ears - now we can hear only groans of pain and sighs of discontentment and sorrow.

Big White Owl.

3. STRATEGIES.

A Wide Angle Perspective

In this document we are not attempting to tinker with an existing system of mental health services for children and families. The mandate discussed in the previous section offers a perspective that encourages us to stand back from what is and speculate about what might be possible if we shift our attention from 'illness' to 'health'. We are challenged to create new ways of mobilizing professional and community resources around the developmental needs of children and adolescents, without resorting to the simple formula of demanding more and more specialists concerned solely with pathology. We are inclined toward confronting attitudes that regard childhood as merely a stage in preparation for adulthood. We feel obliged to question practices that isolate personal distress from the social context and compartmentalize individuals according to professional interests and specialities. In the final analysis, we wish to oppose the belief that a system of mental health services should assume direct and total responsibility for the psychological and emotional well-being of the community.

From our definitional base, 'childhood' and 'adolescence' are experiential states rather than ascribed statuses. As such, they should be understood as parts of life and not as preparations for life. They are critical periods of learning, uniquely experienced within the context of particular relational networks. Nurturing and caregiving are, then, specialized activities directed toward the individual needs of the young person. Such influences are not uni-directional, however. In interactional terms, the adult/child relationship represents a particular kind of partnership that embraces its own peculiar set of expectations, demands, hopes and aspirations. For these, and other reasons, we believe that mental health services for children should be functionally and philosophically separated from services that are directed toward the needs of adults. In our view, such services should be legally mandated through separate legislative provisions and resourced through separate administrative structures.

Given a broad legal and administrative mandate for children's mental health services, we are not suggesting that all programs and strategies should operate under the auspices of the same jurisdictional umbrella. On the contrary, an ecological approach would imply that mental health needs might be identified and addressed across a broad range of social and professional structures. The key lies in the ability and willingness of such structures to collaborate within a broad philosophical framework and shared commonality of purpose. In this regard, a service that specifically adopts a children's mental health mandate might be expected to take the lead.

Within a collaborative network, the particular strategies of education, prevention and treatment should, of course, emerge from the assessment of needs identified within the particular community. On the other hand, the orientation outlined thus far implies that attention be given to some specific priorities.

Education

Without evidence to the contrary, it seems reasonable to assume that most parents and caregivers in Canada are blissfully unaware of the developmental needs of children and adolescents. A recent report published by the Mental Health Division of the Department of National Health and Welfare suggests:

> An additional yet important factor is that of our society's rapid social evolution. This has led to an increased sense of puzzlement for families and other child caregivers who search among shifting values for an adaptable and useful conceptual framework by which to guide their activities (p. 2).

The conclusion seems to be that, as a society, we are seriously lacking in knowledge, understanding and, perhaps, even commitment to the social, psychological and emotional well being of our children. Meanwhile, most of our mental health experts seem intent upon protecting the exclusivity of their knowledge while fighting their heroic, though uncoordinated, battle in the trenches. Unfortunately, they appear to be losing the war and the constant call for reinforcements is being seriously questioned in terms of both economics and the effectiveness of the troops themselves. Perhaps the time has come to focus and coordinate our troops on the battle field and devote a greater proportion of our resources to the cause of 'peace'.

Mental health professionals may choose from a variety of reasons to avoid the more peaceful arena of education, e.g. there is no mandate; time is money; the casualties are too much in need; the concern is with 'abnormality' rather than 'normality'; specialized knowledge cannot be understood by the uninitiated; outcomes are too ambiguous and diffused; it is personally less satisfying, etc., etc. The reasons may, of course, be valid. On the other hand, our mental health standards would attain complete fulfillment if every caregiver, parent or surrogate could be considered as an expert. We cannot begin to move in this direction until the necessary knowledge and skills are made available by those who already possess them to those who most need them. In this regard, the community must look to the professionals and the professionals must be prepared to deliver. This would, of course, require the translation of many pathology concepts into normative models.

An educational mental health strategy represents the highest form of adherence to the principles and standards outlined in the first section of this paper. For our purposes, we would define Education as the dissemination of information and the teaching of skills relevant to the needs of the recipient. Ultimately, the students must decide and, in some cases, the teachers may have to modify their curricula accordingly. We are not, therefore, advocating the pedantic principle that "teacher knows best". Rather, we begin with the more humble question of "how can we help?". The chances are that questions regarding the etiology of specific pathological states will be rare but, presumably, there will always be experts ready to provide enlightenment.

The responsibility for providing educational services to the community cannot, and should not, fall exclusively upon the identified children's mental health service. In every community there are professional and non-professional groups that are more adequately prepared to do the job. Schools, colleges, health units, community associations, employers, child welfare agencies, hospitals, service clubs, trade unions, families and fraternities are all potential educators. In Canada we would like to draw particular attention to the efforts of the Canadian Mental Health Association and the Canadian Council on Children and Youth. Such groups represent ongoing normalized components within the structures of a community that can be empowered to provide information, support and, in some cases, the teaching of skills.

The task of the designated children's mental health service would be to provide leadership, establish a shared philosophical framework, develop mechanisms for collaboration and coordination and provide the necessary support, information and expertise as required. Strategically, this would probably require the establishment of an 'education unit' that would have the necessary mandate to draw upon all of the specialized resources contained within the mental health system.

Prevention

As with education, there are many reasons not to allocate resources and develop strategies in the

area of prevention, e.g. the concepts are poorly defined; strategies are generally broad and abstract; evidence of 'success' is equivocal; resources are simply not available; epidemiological evidence does not present causal models; mental health specialists should not be primarily concerned with normative processes, etc., etc. For these reasons, Isbister (1975) has referred to prevention as "corralling a cloud". We would respond by suggesting that such a cloud may be no more pervasive and ubiquitous than the mist that currently shrouds the mental health arena.

In our opinion, prevention should not be regarded as an alternative to treatment services, but as a necessary adjunct to them. The physician who successfully assists a patient in combatting pneumonia is on an endless pathway unless other members of her profession are concerned with the conditions in which the illness seems to manifest itself. Isolating the critical variables, creating the appropriate concepts, developing workable models and testing out preventative strategies are all part of the professional commitment. In medicine, many more lives have been saved through preventative public health strategies than through direct individualized curative treatment. Lest we should be accused of formulating a medical model for mental health services, we might also point to the invention and adoption of seat belts in motor vehicles although, in this case, it did take the determination of a Ralph Nader to convince the motoring public to pressure the automotive industry to respond.

In children's mental health, a commitment to prevention is more than just a professional ethic. Since our ultimate objective is to enhance the overall competency and well-being of children and caregivers in our communities, we must begin to look beyond the casualties and concern ourselves with strengthening the 'normative' processes. For a host of reasons, we cannot continue to stand by while increasing numbers of children and adolescents become caught up in our direct service networks. Apart from the human distress that precedes treatment, combined with the effects of labelling, segregating and objectifying these young people, the financial costs of the exercise have become monumental. It has been estimated that the direct costs of caring for a severely disturbed or dependent person in Canada amounts to ten million dollars, spread over a life time of service.

In spite of all of this, it seems that we are not even able to meet the growing needs of the acutely and chronically impaired. Our treatment services cannot possibly be extended to the fifteen to twenty per cent of the juvenile population deemed to require them (Knitzer, 1982). In addition, it appears that those who do receive services are not necessarily the most in need (Rutter et al, 1970; Barrette et al, 1980) and even when such services are provided, their effectiveness remains questionable (e.g. Romig, 1978).

Given this bleak and discouraging picture, we have firmly concluded that prevention should be a major strategic thrust within a children's mental health service. In the light of our basic premises and standards, we have questioned the legitimacy of such a strategy in terms of supporting and respecting the autonomy of individuals but are of the opinion that, developed appropriately, it can do no less than enhance the options and choices available to those who wish to benefit from such services. We have questioned the desirability of inviting mental health professionals to move out of the trenches in order to consider the quality of life from a broader perspective and we consider this to be an essential step in integrating professional and community aspirations. In short, we fail to see how our overall objectives can be addressed without making prevention a priority issue.

As a point of departure, we support the position of the Department of National Health and Welfare

that conceptualizes prevention as an *attitude* rather than a *program*. In their terms:

> Prevention is an attitude, questioning, enquiring and imaginative, and also unencumbered by the constraining of narrower perspectives that too often characterize particular work settings and daily routines (p. 6).

In moving from belief to concept and strategy, however, it is important for us to begin to define exactly what we mean when we talk about prevention in the area of children's mental health.

In the mental health literature, most contributors have followed Caplan's (1964) lead in making a distinction between *primary* prevention and *secondary* prevention. The essential goals of the former are to optimize psychological well-being and prevent the onset of psychological maladjustment and disorder. As a general strategy, it can be differentiated from education to the extent that it is focused upon the prevention of specific forms of 'maladjustment' and is directed toward specific high risk groups. According to Emory Cowen (1986), a major contributor to the field, a primary prevention program must meet three structural requirements:

1. It must be group, rather than individually oriented (even though some of its activities may involve individual contacts).
2. It must have a before-the-fact quality, i.e. be targeted to groups not yet experiencing significant maladjustment (even though they may, because of their life situations or recent experiences, be at risk for such outcomes).
3. It must be intentional, i.e. rest on a solid knowledge base, suggesting that the program hold potential either for improving psychological health or preventing maladaption (p. 132).

In targeting particular groups, preventative planners have used a wide variety of assumptions about the conditions that contribute to a child's vulnerability to potential psychological disorder. Factors such as poverty, parental conflict, early school failure, early childhood trauma, inadequate social skill training, lack of effective emotional support, developmental delay, biogenetic abnormality etc., etc. have been linked to the subsequent development of pervasive stress and personal maladjustment. Based upon etiological studies, preventative strategies have attempted to break down the causal chains by intervening at various points in the configuration. The overall purpose of these approaches is generally defined in terms of reducing negative outcomes, i.e. the prevalence of identifiable disorders.

Given the orientation developed through this paper, however, we would prefer an approach to primary prevention that focuses upon positive outcomes, i.e. outcomes that reflect an improvement in the quality of life for children and their caretakers. This is not to suggest that we should abandon the cause of reducing the prevalence of psychological disorders in children and adolescents, or that the pursuit of global mental health will ultimately abolish all forms of personal disorder or distress. Predisposing factors that increase a child's vulnerability to such conditions certainly assist us in identifying 'at risk' groups but we appear to be a long way from establishing 'causal' models that might direct the course of prevention.

In the environmental domain, the search for causality is complex and confusing given the multiplicity of variables and the potential interaction among them. On the other hand, the work of Michael Rutter and his associates does suggest that, in most cases, the developmental damage to a child is more a product of the disruption, discord and disharmony in primary relationships than the identified precipitating factors themselves. The implication seems to be that, regardless of what causes what, the development and maintenance of satisfying relationships within the family or surrogate family

can do much to offset the course of pathology in the child. This would indicate that the most effective pathway to prevention might be contextual and that personal destiny and growth are inextricably bound up in the quality of relationships with others.

The focus upon relational networks does not imply that preventative strategies must necessarily be fuzzy, overly diffused and non-specific. Overall objectives may be determined (albeit in normative terms), goals may still be identified in terms of reducing the incidence and prevalence of disorders and specific groups may be targeted. In evaluation, we would argue for the use of multiple and aggregated outcome variables relevant to both promotion and prevention. This does not exclude specific programs such as Social Skill Training (Shure & Spivak, 1980) or Social Support Enhancement (Mitchell, Billings and Moos, 1982), as long as the intervention is designed to encompass the relational or interactional context (Mireault & Royer, 1983). The content of such programs should, in our opinion, focus upon problems currently being experienced by the clients and be directed toward the enhancement of competence rather then the 'curing' of deficiencies.

By taking the more positive pathway toward primary prevention, it is possible to retain a greater degree of fidelity to our original principles and standards. The identified target groups could then become those where substandard conditions are either identified or suspected. It is also more in line with our belief that individual children and caregivers should be actively encouraged to take increasing responsibility for their own wellbeing and that, wherever possible, professionals should be in a position to offer support, through positive collaboration, rather than remedial, or even preventative, intervention. To resort once again to a medical analogy, physicians recognize the benefits of a healthy cardiovascular system but their patients decide whether to go jogging, play golf, take up gardening or take to the slopes.

In spite of our idealism, we clearly recognize that prevailing attitudes, systems and practices are not conducive to the cause of primary prevention. The chances are that remedial intervention will continue to be more compelling in terms of identified needs for individuals considered to be unable to help themselves. Unless considerable pressure is applied, mental health professionals will have little incentive to move toward prevention, being caught in systems in which, "patients are reimbursed upon developing illness and providers for treating it; and no one is reimbursed for preventing it" (Okin, 1977, p. 294). As long as service providers control the necessary financial resources there appears to be little hope of making mental health a community responsibility. Nevertheless, we are optimistic that policy and administrative changes can do much to encourage a more preventative climate that calls for a different kind of exchange between professional and client.

Our particular view of primary prevention outlined above does not follow the traditional definitional pattern but, in our submission, it does remain faithful to an ecological framework that places ultimate responsibility in the hands of the community, with professional support and encouragement. It begins with open and honest human contact and takes direction through individual and group commitments to improving the overall quality of life for both children and caregivers. In this regard, we believe that a children's mental health service should provide the leadership, support and, where necessary, the resources. Using evaluative methodologies, such a system could also create the necessary feedback loops through informational and evaluative systems. While such data would provide a planning base for the mental health system itself, its primary purpose would be to keep the community informed about the quality of life experienced by children and those who struggle to cater to their needs.

In our schema, *secondary prevention*, should be more directed toward the goal of arresting the development of identifiable disorders through early detection and treatment, using the least intrusive, effective methods with the child and the family. As primary prevention is intended to reduce the need for remedial action, so secondary prevention is intended to reduce the need for more intensive approaches. We are still concerned with the same overriding principles of not hooking clients into the 'system'; maintaining support networks; mobilizing family and community resources; normalizing our intervention methods and maintaining the flexibility to meet the individualized needs of the client.

A strategy of secondary intervention might involve the identification of incipient disorders, with informational and counselling support provided to both the child and the caregivers. It might also include providing similar services where established disorders have been detected and management skills are generally lacking. In this regard, there is considerable evidence to suggest that many critical life experiences such as pregnancy, separation and loss, physical illness, etc., are associated with increased stress and the onset of developmental problems (Bower, 1961; Wallerstein and Kelly, 1979). Even where no such factors are readily apparent, there is compelling evidence indicating that the problems experienced and presented by severely disturbed adolescents can be traced back to indicators manifested in early childhood. In a recent study of chronically troubled youngsters in British Columbia, Ferguson (1986) has shown that many of the precipitating problems were identified, and recorded, during the pre-school years. Predictably the same data show that very little was done to address the problems until they became intolerable to caregivers and the community. Similar findings have emerged from comprehensive studies dealing specifically with pre-school children (e.g. Rolf & Hasazi, 1977). Despite the questions raised about assumed causality and predictability, it is readily apparent that such evidence should not be ignored in the identification of children at risk.

The detection and identification of problems, however early, does not automatically reveal the most appropriate form of intervention. However, desirable it might be, there is no linear relationship between 'diagnosis' and treatment in mental health that can be likened to the treatment of physical ailments in Western medicine. Furthermore, it is apparent that all children and caregivers within any 'diagnostic' category do not respond the same way to any given treatment approach. In reality, clinicians are generally faced with a wide range of individual and family focused treatment options that may be based upon the characteristics of the child, the family or the service delivery system. Preferred approaches are frequently determined by the particular skills and orientation of the practitioner. In making such decisions it seems that clinicians tend to consider: the degree of danger to self or others; the degree of the clients contact with reality; the presence or absence of a supportive family (Friedman and Street, 1985).

In their analysis of admission and discharge criteria for various mental health programs, the same authors suggest that decisions to provide treatment services for children and adolescents should be based upon the 'least restrictive alternative' principle. In support of this position it seems that children placed in restrictive hospital settings, for example, do not fare better than children with similar problems who are treated in the community (Prentice-Dunn, Wilson & Lyman, 1981). In this regard, it appears that educational and vocational placements turn out to be the most powerful forces available in interrupting patterns of chronic psychiatric hospitalization (Friedman and Street, 1985). Similarly, the evidence pertaining to intensive in-home intervention and support is becoming increasingly encouraging (Kinney, Madsen, Fleming & Haapala, 1977; Friedman and Quick, 1983).

As Behar and Burchard (1984) suggest, however, some pressure is required to counter the pervasive tendency for mental health professionals to consider that children require more restrictive interventions than are actually necessary. On the other hand, the same authors have also shown that this tendency diminishes significantly when a full spectrum of services is made available.

Given that we have no universal answers to the issues of secondary prevention, we would continue to rely upon the principles and standards that have already been articulated and exemplified throughout this paper. In service provision, we seem to require a broad range of programs that can be readily accessed by the consumers and tailored to individual needs. Since we cannot readily predict the course of difficulties from early detection, or the response to particular treatment methods, it would seem wise to retain as much flexibility as possible in the availability of such services. In other words, we should not become overly specific in determining the criteria for access to a particular service and we should be cautious of bypassing less restrictive services purely on 'clinical' grounds. In short, we should attempt to deliver services in a non-categorical manner as much as possible.

In spite of our best intentions it is still reasonable to expect that, even in the arena of secondary prevention, there will be occasions when highly restrictive short term measures will be deemed necessary. In this regard, the removal of a child from the home may constitute the least restrictive effective alternative. This does not necessarily mean that we have shifted to a more long term or 'tertiary' approach. Short term stabilization or treatment may well be used as a strategy to prevent the development of pathology that is still considered to be embryonic. We would argue, however, that this type of approach should be primarily restricted to those cases where there is some immediate danger or risk to self or other that cannot be reasonably contained through less intrusive measures.

Our approach to secondary prevention is not substantially different from our beliefs about primary intervention. Clearly there is more need for direct professional intervention but, essentially, the primary agents of change are seen to be the child and the caregiver. In this regard we would not necessarily choose to target one or the other since, in many cases, our concern should be with the relationship as an interactional unit (Mitchell et al, 1982). The principles and standards for mental health remain significant although, in targeting particular groups, the system would require more information relating to the incidence, prevalence and duration of identified risks and problems.

To a large extent, it may not be necessary to develop a totally separate strategy of secondary intervention. Much could probably be achieved if practitioners could be encouraged to think preventatively and re-organize, or re-direct, their activities accordingly. Again we should stress that we are not talking exclusively about professionals working within the structures of a defined mental health service. Individuals who work in public health units, community clinics, schools, hospitals and private practice are not only in the arena but, in many cases, are more a part of the normative structure of the community. Often they turn out to be better prepared, better trained, more accessible and more 'acceptable' than the so called mental health worker. Once again, we are inclined to suggest that a defined children's mental health service should provide ongoing support, encouragement and coordination of services offered by these practitioners. Once again, we suggest that a wide variety of non-professional individuals and groups could be, and should be, co-opted into the community effort. As Michael Rutter has indicated, the only successful approach to prevention is to cover the community in as many ways as possible using

as many resources as are available.

While each community might be expected to contain its own unique configuration of actual and potential 'mental health' resources, we would cite the following examples where underutilization is a distinct possibility:

1. The School. With the possible exception of the family, the school represents the primary context through which children acquire information about themselves, others and the worlds in which they live. Relationships with teachers in the early years and peers at a later stage, profoundly influence not only academic performance but the general course of psycho-social development. In this sense, the classroom is not just an arena for the early detection of developmental problems. Rather, it should be viewed as a formative, nurturing environment, capable of promoting mental health and, where necessary, providing individualized support and remediation for children who encounter particular difficulties. From this perspective, school systems that claim to deal only with the "cognitive development" of the child, commit the cardinal sin of denying the child's own subjective experience. There is ample evidence, for example, to convince us that early school experiences are critical in the development of the child's sense of self, particularly in the area of self esteem (Purkey, 1971; Curtis, 1978).

We suggest that, beyond the family, the school should be considered as the most essential children's mental health resource in the community and teachers as highly significant caregivers. Wherever possible, mental health programs should work in support of the teacher and mental health professionals should be available as integrated members of the school community. Where school counsellors, psychologists and other mental health workers are employed within the school, the mental health system should be available to provide consultative, or back up support. In order to promote mental health in the school, however, it seems that the roles of these professionals might have to be re-examined (Nolan, 1978). As Lapides (1977) has indicated it is quite possible for school psychologists to take an ecological view and become proactive, rather than re-active, to the needs of children and teachers. Where such personnel are not readily accessible, the community mental health service should provide appropriate 'in-house' resources as well as the necessary back up specialized services. While we believe that mental health professionals working in the schools create a more 'normalized' service, it is also possible for external consulting teams to be available to schools on an 'as needed' basis (Kandler, 1979).

From our point of view, the most important aspect of building mental health resources into schools is that both the teacher and the mental health worker share a common concern for the total wellbeing of the child, rather than for the preservation of professional or jurisdictional boundaries. In other words, we need an attitude first and a system second. It is also central to our position that the primary caregiver (i.e. parent or surrogate), along with the child, be directly involved in any form of individualized remediation or intervention. In our experience, the blending of perspectives across school and family calls for a specialized set of skills, not normally found in either the school system or the mental health system.

2. The Medical Practitioner. For most children, visiting the family doctor is accepted as being a normal part of growing up in the community. Enlightened family physicians, pediatricians, public health nurses and other allied health professionals have come to recognize that physical, emotional and psychological health are integrated aspects of child development that should be considered together in the delivery of services. As Goldberg (1980) has noted, pediatricians in the United States see many more children with 'mental health' problems than

their colleagues in child psychiatry. Silver (1982) goes on to suggest that such practitioners are frequently in the best position to assess the nature and implications of such problems within the broader context of the child's development.

In recent years, there has been increased interest in the role of psychologists in primary health care and there is some evidence to suggest that active collaboration among physicians, psychiatrists and psychologists, can actually reduce the use of costly health care programs and facilities (Graves and Hastrum, 1981). In addition, we have already alluded to the significant role of the public health nurse in the arena of primary prevention and would argue that this role should not exclude the possibility of direct involvement in 'secondary' approaches. We would suggest, however, that our standards for treatment intervention apply, regardless of the speciality in question. In this regard, it would become the responsibility of the designated children's mental health system to ensure that such standards are met and that the necessary back up resources are made available.

In short, we support the position that physical health and mental health are closely inter-related issues. As we cannot expect specialized practitioners to be all things to all children, we can only hope that integration might occur through close inter-professional collaboration, with a common commitment to the total wellbeing of the child within the contexts of the family and the community.

In blending these two aspects of health, the role of the psychiatrist becomes absolutely critical. Apart from the knowledge and expertise contained within their own discipline, psychiatrists are clearly in an ideal position to provide leadership and encouragement in bringing about philosophical, theoretical and practical unity of purpose. In spite of the acute shortage of child psychiatrists in most regions of Canada, our experience suggests that increasing numbers of these practitioners are becoming more and more concerned with the overall conditions of service delivery. We support their concern and applaud their efforts. In our opinion, tedious professional rivalrys have persistently hampered the development of the mental health field and the efforts of concerned psychiatrists to bring the issues out into the open represent a critical step toward a negotiated peace.

3. The 'Church'. For a variety of reasons, mental health professionals have considered the spiritual needs of children to be beyond their domain. While we understand their apparent reluctance to bring religion into the mental health equation, we firmly believe that spirituality lies at the very foundation of our lives, regardless of the particular form it might take. For some reason, we seem to be more accepting of this proposition when applied to cultures other than our own. Of course, it is an issue that arouses considerable passion in many areas and it would be impossible to adequately deal with the subject within the scope of this paper. Rather than avoid the matter, however, we simply appeal to professional practitioners to acknowledge the importance of a child's spiritual needs without judgement or prejudice. Meanwhile, we need to recognize that spiritually concerned groups, including the orthodox church, represent some of the most cohesive and supportive communities within society. To ignore their existence is to dispense with some of the most potentially powerful, and relevant, influences that effect the lives of children and their families. In this regard, we are talking about the broad influences of such groups and not merely those segments that relate specifically to mental health in the traditional sense, e.g. pastoral counselling services.

4. Child Care. Over the past decade, Child Care has been one of the fastest growing professions in North America. In this development, it is generally recognized that Canada leads the way. Nurtured within the melting pots of residential programs,

professional Child Care has now moved out into schools, homes and communities. Professional associations, publications, national and international conferences, undergraduate and graduate programs, have all emerged in support of the "new kids on the block". In Alberta alone it is now estimated that there are over fifteen hundred child care workers employed in a variety of settings and programs. As a potential resource to a mental health system, these practitioners are invaluable.

With the advent of deinstitutionalization, it seems likely that increasing numbers of child care workers will be available to provide new and innovative approaches at the community level. Individually and collectively, child care workers have demonstrated a healthy disregard for many of the old traditions that, in our opinion, have served to inhibit a progressive approach to delivering children's mental health services. As frontline personnel, relatively free from the encumbrances of office routines and bureaucratic restrictions, their direct impact could be, and in our opinion should be, enormous. Unless definitive moves are made to harness this potential resource, however, it could dissipate as rapidly as it developed if 'deinstitutionalized' workers are not provided with opportunities to become involved in community based intervention. In our view, this would be a tragedy and we would encourage a children's mental health system to accept the challenge, while it is available, by incorporating Child Care within its spectrum of resources.

5. Community Social Work. In a general sense, it appears to us that Social Work is a more generic and diffuse profession than Psychiatry, Psychology, Nursing and the like. On the other hand, professional Social Work frequently reflects the ecological perspective advocated here. In the literature, the term social work is used to cover a wide range of activities that impinge upon the arena, commonly defined as mental health. At this point, we are not concerned with those branches of clinical social work that find their homes in the mental health domain but with individuals who work in child welfare systems, community support programs, family services, youth clubs and similar locations.

In some cases, child welfare workers carry a legal mandate that specifies a high level of accountability for the wellbeing of children and determines the nature of the services to be provided. Frequently, the needs of children and adolescents receiving child welfare services are also deemed to require the involvement of mental health professionals, giving rise to questions about who does what? on whose authority? and for what reason? In our initial discussion paper *Service Philosophy, Principles and Guidelines,* we proposed the use of a model designed to address these issues within the framework of the Alberta system. While we have no fundamental commitment to any particular mechanism, our position is based upon some principles that should be specified here.

Throughout this document, we have argued that, wherever possible, mental health services should act in support of primary caregivers, whether parents or surrogates. Since many child welfare workers legally assume the latter role, they become ultimately responsible for the child's well-being, including the nature of the services provided. Hopefully, this responsibility is maintained only until the parent can re-assume the role or a more appropriate surrogate can be found. Meanwhile, the child welfare worker should be empowered to act in the best interest of the child.

The argument, often used by mental health professionals, that such workers are "unqualified" to perform this role can never justify a 'takeover' by the mental health system. This problem, if in fact it exists, rests with the managers of the child welfare system and should be resolved within that jurisdiction. This does not mean that mental health professionals are clinically accountable to the child

welfare worker any more than the surgeon is medically accountable to the parents of a child placed in an intensive care unit. On the other hand, both of these examples imply a particular kind of accountability exemplified through the growing number of legal actions being taken across the continent of North America.

In our view, we step into hazardous territory when we fail to recognize the accountability and responsibility of the primary caregiver. Furthermore, we stand in violation of our own principles if mental health workers begin to assume total responsibility for the well-being of children or, even worse, compartmentalize the child to satisfy artificially prescribed boundaries to preserve professional autonomy. All that we have said about education, information dissemination, collaboration and shared commonality of purpose needs to be applied if such service arrangements are to work in concert toward promoting the well-being of children.

As indicated earlier, there are many other 'social workers' providing diverse services to children and families within the community. While their roles, experience and qualifications may prohibit them from involvement in 'treatment' intervention, they are nevertheless important community resources to be mobilized through an effective children's mental health system.

Addressing Special Needs

At this point we have chosen to deviate from Caplan's original model of prevention by replacing the "tertiary" component with a 'special needs' section. For present purposes, we offer the following general description of children who might fall into this special needs category:

> A 'special needs' child refers to one who by virtue of mental, emotional, behavioral, physical, neurological or developmental problems and disabilities, requires specialized mental health intervention in order to achieve her or his highest potential of functioning. 'Special need' is defined as a need that cannot be met through the normal service delivery channels, frequently requiring services drawn from more than one service provider or jurisdiction.

This is the population that is traditionally regarded as being the direct concern of a children's mental health service. We also believe that this group presents a range of needs that must be adequately addressed if the system is to live up to its own expectations and those of the community. In this regard, the system must first establish the broad parameters for the delivery of direct treatment services.

Mental Health Treatment Services: In our framework, the provision of treatment services, as defined in the first section of this document, is the direct responsibility of a designated children's mental health system. Based upon a thorough assessment of need, including 'diagnostic' information, such services may cover a broad range of psychotherapeutic interventions directed toward either individuals or groups. Traditionally, such services are frequently considered to be the most intrusive, intensive, and expensive options that should be reserved for clients who have either slipped through the preventative net or have failed to respond to other forms of intervention. We wish to challenge this view from the outset.

As a statement of principle, we believe that services should be provided on the basis of identified need, with full consideration given to the willingness and capacity of the client to respond. From this perspective, the services of a mental health professional may be appropriate regardless of the diagnostic label, acuteness or chronicity of the problem, or the interventions previously attempted. In our submission, professional mental health services should be available to the general public

without restrictive preconditions. This does not imply that a mental health professional is obliged to provide any type of service requested by a particular client, or that the client should not be referred to some other agency where appropriate. In establishing this principle, our primary intent is to encourage the individual who voluntarily seeks help from a particular service provider.

Having made this point, we would like to concentrate in this section on the provision of services to children and families where acute or chronic difficulties have been identified. While many of these clients may, in fact, have fallen through the mental health safety net or failed to respond to other preventative approaches, others may have become caught up in social service networks or juvenile justice systems. Regardless of their particular status or location in the system, the right of access to a children's mental health service should be upheld.

Again, we would argue that the available treatment services should be based upon need; tailored to the individual needs of the particular child and caregiver; provide options to the client and be based upon the principle of the least restrictive effective alternative within the most 'normalized' community context.

Needs Based Services: In proposing a needs based approach to service delivery, we are not challenging the efficacy of diagnostic systems in helping clinicians to bring some order to the otherwise chaotic world of psychopathology or mental disorder. Our concern is more with the obvious lack of linearity between diagnosis and the most effective treatment approach. We would argue, for example, that the automatic use of behavior modification techniques with 'conduct disorder' children does not attend to the issue of differential need. By the same token, children with "pervasive developmental disorders" may, along with their families, respond to a variety of approaches, offered by a variety of professionals, in a variety of programs.

With children in particular, an individual diagnosis alone may not take into consideration the many situational and developmental variables that contribute to the problem and, potentially, form part of the solution. In our view a treatment strategy should not only consider these factors but should also take into account the preferences and abilities of the client to work with a particular approach. While a particular diagnosis or individual assessment may not, in itself, indicate a particular mode of treatment, or even a particular type of service, the problems identified may well require specialized skills and sensitivities. The knowledge and skills necessary to deal with the trauma of sexual abuse may be quite different from those required to treat various forms of thought disorder and we are certainly not questioning the need for professional specialization. Rather, we are suggesting that treatment services should not be directed toward 'target populations' as defined by limited diagnostic criteria. Our concern is with the well-being of the total child as a developing social being and this calls for a broad ecological approach to service delivery. Again, this underscores the desirability of making a clear distinction between children's mental health services and services directed toward adult populations.

In making the above comments, we are not suggesting that all mental health programs, whether residential or community based, should be capable of meeting the needs of any client that happens to arrive on the doorstep. The real challenge is to identify need configurations, rather than symptom clusters, as a basis for mobilizing resources and defining the parameters of particular programs. At first glance, this might appear to produce some strangely blended target populations, but the ultimate test should be the ability of the program to meet the individualized needs of the individual

child within the context of the family and the community.

In advocating for a needs-based approach rather than one based on diagnosed disorders, it is important that we make our position clear. In the most general sense, the needs of children and adolescents are closely related to the general standards and expectations that prevail in any given community. As such they are implied by the standards or principles that the mental health service chooses to adopt. Depending upon the particular orientation of the system in question, the specific needs of children may be defined in terms of Maslows' revered 'hierarchy' or follow a developmental schema exemplified by the work of Piaget.

More recently, Pecora and Conroyd (1982) have proposed four sets of mental health needs, essential for optimal growth and development.

1. The need for sensory stimulation. This refers to everyday opportunities for children to make full use of their five senses. Activities and interactions that provide such experiences are critical in the development of cognitive skills, language, communication and sensorimotor coordination.

2. The need for stable, and trusting relationships with an adult. Such relationships provide the critical context for intellectual and emotional development (Rutter, 1979). Where this need is not addressed, children tend to develop a wide range of emotional and behavioral disorders (Salasin, 1977).

3. The need for competence and self esteem. Opportunities for children to become socially competent are necessary if many of the problems associated with anti-social behavior, failure expectations and withdrawal are to be avoided. In addition, such opportunities should also contain the message that the child is respected, cared for and recognized as a worthwhile human being.

4. The need for physical well-being. We have already alluded to the inter-relationship between physical and mental health earlier in this paper. In this context, Berlin (1975) also includes adequate health care for the mother during pregnancy, a balanced diet, adequate medical and dental care, adequate housing and clothing and protection from physical and other hazards.

In addition to the above, the standards identified earlier in this paper also suggest the inclusion of needs in areas such as spirituality and behavioral learning but the point to be made here is that the treatment or remediation of specific mental health problems should, in our view, be directed towards such needs using, wherever possible, the child's natural living environment.

In planning a mental health service, there are numerous ways in which mental health needs may be classified and assessed. Jaffee (1982), for example, identifies "normative needs", "perceived needs", "expressed needs" and "comparative needs" as useful classification categories. Assessment methods and techniques include surveys, social indicators, selective community opinions, service statistics and a variety of others that cannot be reasonably described within the scope of this paper. For system planners interested in these methods there is a wealth of literature in this area to be tackled.

Sealing the Cracks

The children's mental health literature suggests that approximately ten percent of children requiring services somehow "fall between the cracks" of the service delivery network (Glick, 1981). This problem is usually related to (1) the availability of appropriate services; (2) the state-of-the-art in addressing particular problems; (3) the applications and misapplications of particular 'labels'.

In such situations, services may be denied or, even worse, the child and the service may be hopelessly mismatched. While children affected by this inadequacy in service delivery may exhibit a wide range of special needs, we must also include children whose 'diagnosis' covers more than one particular category. Apart from presenting a varied range of problems requiring specialized treatment expertise, such children also require a broad spectrum of services including long term care and treatment, family support, community based facilities, reintegration programs, educational support and early intervention. In the past, many 'special needs' children have often been confined to institutions having been labelled as "problematic", "retarded", "difficult to serve" or "untreatable". Consequently, access to less intrusive services in the community has frequently been denied. Where community placement has occurred, treatment and support services have often been sadly lacking.

At times, the problem has been attributed to the actions of agencies that insist on selecting their own clientele. From the agency's perspective, however, there are often good reasons for not accepting all of the children or families as clients. It may well be that the services offered are clearly not appropriate or that the problems posed by the perspective client are beyond the agency's particular area of expertise and experience. From this perspective, a misapplied service may well result in regression, acting out, premature discharge, or the merry-go-round of revolving transfers. Nevertheless, the denial of service can be frustrating and disheartening for families and referral agents, especially if the reasons for such rejection are unclear or the child in question is simply shuffled from one agency to another.

In accordance with our equal access principle, we support the view that the provision of a particular service should be based upon the needs of the client and not, as it sometimes is the case, on the structures and requirements of service agencies and institutions. Where the special needs of children are not being met, the most appropriate agencies should be actively encouraged to develop the services that do, in fact, attend to the needs. The critical test for a children's mental health service system will be the ability and willingness of service providers to meet the needs of the most difficult or "hard to serve" children and families. From this perspective, system administrators and service providers must be obliged to make special efforts in order to address the special needs of individuals considered to be in need of mental health resources. In order to avoid the 'institutionalization' solution, the development of community outreach programs and community residential facilities that attend to the total needs of the individual, represents a high priority issue within the spectrum of children's mental health services.

Services to Native Children and Families.

In our view, mental health services for Native children and their families require separate and special consideration. While many of our general principles might be appropriately incorporated into a broad strategy, our understanding of the issues and implications often leave much to be desired. Concepts such as health and ill-health need to be re-examined along with our traditional ways of addressing treatment issues. The cultural, ethnic and geographical diversity of Native peoples makes it virtually impossible for us to talk in terms of a "target population". The problems presented and perceived by Native peoples are not necessarily those identified in the population at large. In our attempt to understand the ongoing struggles of Native peoples, we must constantly address issues of history, culture, values, spirituality, status, geography, urbanization, tribal characteristics, economics and treatment.

Given our overall state of naivety, it is hardly surprising that our mental health orientations and methodologies are grossly inadequate and that young native people are monumentally over represented in our service delivery networks. As service providers have become disenchanted with the apparent lack of response to their efforts, Native individuals, groups and communities often regard such agencies as "pushy", "baby snatchers", "uncaring", "superior", "nosey", "inflexible" or "something to be feared". The result has often been the delivery of fragmented and inappropriate services that are disruptive at best and, at worst, destructive.

In our opinion, we will not effectively address these issues by simply tinkering with our existing service delivery systems. Nor do we resolve anything when we wash our hands of the problem by simply handing the reins over to Native communities through a gesture of benevolent abandonment. The solution is not to separate the Native child from the dominant society but to recognize that child's needs for security, esteem and autonomy within her or his own family and community. This means that, as with any other community, we should offer support and encouragement to achieve higher levels of autonomy while respecting the cultural variations and differential needs and wishes expressed.

At this point, it may appear that we are now arguing against our initial proposition of giving separate and special attention to the mental health needs of Native children and their families. By way of clarification we would like to suggest that the essential principles offered in this document should be maintained in our approach to supporting Native peoples. On the other hand, any attempt to apply such principles should clearly respect cultural differences, without creating segregation, alienation or patronization. We continue to believe that a child is first and foremost a child, regardless of the racial, cultural, ethnic or economic context .

Obviously, it is impossible to adequately address the issue of mental health services to Native children and families within the confines of this document. Given the significance of this issue, however, the Children's Mental Health Project is currently in the process of preparing a separate paper that identifies some of the major points to be considered and suggests a broad approach to children's mental health based upon the experience and wishes of the Native people themselves.

Individualized Treatment

By implication, we have established the principle that no mental health professional should prescribe or implement a course of treatment without the benefit of a thorough assessment and diagnosis. Regardless of the particular form that this process might take, we believe that the client, whether child or caregiver, should be regarded as a full participant and not as an 'object' to be studied. At all stages, the client should be aware of the judgements being made and be invited to compare these impressions with her or his subjective evaluations. This point is critical if the service recipient is to understand why a particular approach is recommended or indicated. Wherever possible, the client should know what to expect and be in a position to accept, or veto, a recommended course of treatment.

Although this stance may appear to be idealistic to many seasoned clinicians, we believe it to be essential if individuals are to be encouraged to take responsibility for their own psychological and emotional wellbeing. Obviously, many children, and some caregivers, are not in a position to fully understand the nature and implications of a specified treatment strategy but every attempt should be made to provide such information in terms that are readily understandable. Where such under-

standing cannot be obtained, the interests of both the client and the practitioner are best served through the involvement of a third party acting as an 'advocate' for the client. Such provisions may be legally mandated or simply incorporated into the practices of the particular agency or service.

The essence of individualized treatment is that each client be consistently perceived and valued as a unique individual and not merely as a member of a particular group or classification. Working from this perspective, treatment teams and individual practitioners are able to mobilize their own particular skills and available resources in a manner that remains sensitized to the needs, wishes and perceptions of the client. In working with disturbed or disordered children and their families, professional accountability dictates that this individualized focus be embodied within a documented plan of care and treatment. In our framework the plan should indicate that full consideration has been given to the total developmental needs of the child within the contexts of the family and the community. Furthermore, we would suggest that such plans be made available to the client (or advocate) and be amended in the light of changing needs or client feedback.

Providing Options: In all that we have suggested up to this point, the ultimate objective of a children's mental health service remains one of encouraging children, and their caregivers, to assume increasing responsibility for their own sense of personal well-being. This objective emerges from the broader mental health issues of personal autonomy, self-efficacy and individual responsibility. By placing treatment service decisions entirely in hands of professional practitioners, we take the first step in the opposite direction.

In addition to its intuitive appeal, there is compelling research evidence to support the belief that people who consider themselves to be making choices are significantly more committed to the outcomes and experience higher levels of personal autonomy. Since children in general, and mental health clients in particular, frequently question their self-efficacy and often lack a commitment to any course of action, a 'no choice' situation becomes particularly hazardous. A 'take it or leave it' approach or one that attempts to force and coerce may result in resistance, resentment or passive acceptance. On the other hand, a blind belief in the opinions, judgements and decisions of the 'expert' may create dependency or even a state of learned helplessness . . . conditions that some clinicians seem to prefer (Fisher et al, 1977).

For clients or consumers of mental health services to exercise the ability to choose, they must first have access to information. While this might be achieved, in part, through the implementation of an educational strategy, it still presents a significant problem. In the first place, people who find themselves in need of such services are not usually individuals who are inclined to 'research' decisions. Secondly, it is unusual for mental health agencies to advertise their services in an informational way and practitioners are notoriously non-disclosing when it comes to sharing their practices and trade secrets. Thirdly, as a society, we seem to have adopted an "out-of-sight, out-of-mind" approach to mental health problems. Some commentators have gone so far as to suggest that this is one of the reasons why we have become so reliant upon institutional facilities.

Given these tendencies, it would seem that a children's mental health service would need to make a fundamental commitment to disseminating such information in the development of a client-centered system. One way of encouraging this effort might be a strategy that moves the ultimate source of power, i.e., financial resources, away from service providers and into the hands of service consumers. While we do not believe a wholesale transfer of funds in this direction would create

the best service delivery system, we are of the opinion that clients, and potential clients, should be as empowered as possible, without putting at risk the quality or integrity of the services themselves.

Obviously, there are many situations where the client's ability to make choices is restricted through external constraints or personal limitations. In the case of children, legal and developmental factors represent a general set of restrictive parameters that can become amplified with the addition of psychological and emotional difficulties. Additionally, physical restrictions, such as placement in a residential setting, set definite limitations on the options available to a given child or caregiver. Regardless of the limitations, however, there are always *some* choices that can be made by the child and the parent or caregiver and these should be fully understood by all parties involved. Where the child's options are restricted by age, disorder, or restraint, as many of the choices as possible should be transferred to the primary caregiver or the legal guardian acting on behalf of the child. Although there may be situations in which the professional practitioner must make a decision deemed to be in the 'best interest of the client', such decisions should be clearly documented and the practitioner held accountable through the structures of the service delivery system.

In providing service consumers with options, mental health planners must, of course, decide how the infinite variety of identified needs are to be grouped and translated into programatic service provisions, given the availability of professional mental health resources. While we can offer no precise formula to be applied across all circumstances and situations, there are a number of fundamental considerations that emerge from our discussion up to this point.

In the first place, we have argued that services should be built around particular need configurations and not around diagnostic categories or particular styles of intervention. This implies that, within any given configuration, a particular service should be able to offer a broad range of differential treatment options to its clientele. In this way, we would hope to avoid the problems associated with shuffling children and families from agency to agency because of particular labels or needs that are assumed to require a specialized form of intervention. In our view, every program or agency should be capable of treating a child within the contexts of the family and the community. This does not mean that each service component should incorporate all of the many specialities found within the rubric of mental health. In many cases it will be necessary for practitioners to draw upon the expertise of outside professionals but, in our submission, the responsibility for coordinating these efforts should fall upon the primary clinician and not upon the client.

A needs-based service continuum does not prescribe a particular pathway that clients must take through the services network. While we have argued in favor of a preventative model, we do not support the concept of a hierarchically organized system through which clients are moved along as one level is proven to be inadequate or inappropriate. While intervention decisions may be based upon such considerations as resource availability, minimal intervention, personal pathology, family dysfunction, etc., the primary focus should still be upon matching services with needs, giving full consideration to the willingness and capacity of clients to respond. Nor do we support the concept of a levels system in which professional resources are concentrated at one particular level — usually where problems are considered to be the most critical and other services have, apparently, failed. In our view some of these failures are the result of inadequate or inappropriate services provided in these other areas. Rather, we believe that professional resources should be distributed across all

components of the service delivery system as dictated by identified needs. In this regard, it might be necessary for practitioners in short supply, such as child psychiatrists, to make themselves available in a variety of different areas. By corralling such resources in particular areas, such as the mental hospitals, the capacity to offer appropriate and effective services elsewhere is thereby diminished.

The issue of integrating needs-based options within the broadest spectrum of service delivery will be addressed later. At this point, however, we will attempt to exemplify the use of options with respect to one particular component of a children's mental health system, i.e., the residential program.

In a needs-based design a residential treatment program has two essential purposes: (1) to provide a safe environment when there is no immediate threat to the well-being of the client or to others, as a consequence of the client's behavior; (2) to create a therapeutic milieu in which a wide range of treatment resources are integrated around the identified needs of the client in the form of concentrated support and professional assistance. The effects of residential placement can be both powerful and pervasive, particularly in those cases where the client-resident is a willing participant in the process. In those situations where residents and their primary caregivers continue to resist the efforts to provide support, care and assistance, however, the effects are frequently the opposite of those that the program was designed to create. Hence, by removing children from their community settings and sending them to residential treatment facilities, we assault the role of the primary caregiver, cut the child off from his or her primary relationships, challenge the autonomy and the esteem of both child and family, alienate service recipients from the service delivery system and struggle on in the face of resentment, anger and at times, outright hostility. Meanwhile the residential program that is intended to encourage optimal growth and development must contain its good intentions in order to control, coerce or otherwise manage its reluctant residents and their disenchanted caregivers in the community.

In spite of this all too familiar picture, we continue to use our expensive and professionally consuming residential resources as a last ditch attempt to rescue children from themselves and their families or caregivers. All too frequently, such facilities become the instruments for removing all decision making from individuals who were previously considered to be our "clients". With little support from the service delivery system, families and communities, many of these programs have been left with little choice other than to attempt to meet all of the needs of the children placed in their care. This involves developing new sets of primary relationships, creating new learning experiences, providing new opportunities for personal growth and development and somehow, transferring the 'transformed' child back to a community that is unprepared to provide the necessary ongoing support. Of course, such programs are expensive in a total sense but if all the services provided were delivered on a community basis, the costs would be considerably higher. In our view, the problem is not so much in the financial costs of residential services but in the mis-spent time and energy produced by our misuse of them.

As an alternative approach, we would argue for residential treatment programs to be regarded as needs-based options along with all other mental health services. In this sense, residential programs should be encouraged to create highly differential individualized services based upon the specific needs of the particular child, caregiver, and/or family. In attempting to meet a specified range of needs, they should become *part of* a treatment plan and not represent the plan in its entirety, with some perfunctory follow up service tacked on at the end. In other words, those needs that can

continue to be met within the family or community should be identified and incorporated into treatment design.

This, of course, requires the cooperation of the family and other resources such as schools and community associations. Unfortunately, such cooperation is difficult to establish if the child has already been 'kicked out' or 'wrenched out' of these options in order to establish the necessary criteria for residential placement. The answer lies in considering the potential of using a residential service well before these events have taken place. This means that all information must be made available to the child, the caregiver and other interested parties and that the role of a residential service be fully articulated and documented. The emergent plan should be a statement of collaborative effort involving the child and all of those who are attempting to provide care, education or treatment. While such a plan would represent a collective statement of accountability, ultimate responsibility to oversee its implementation might be assigned to one primary service provider, accountable to the group in general and the primary caregiver in particular.

To offset an anticipated challenge from those who would consider us to be naive, we do acknowledge that most children or adolescents would not freely choose a residential service. We also know from experience that some families are reluctant to make such a decision, even where such a service is clearly indicated. Unfortunately, we are also aware that some caregivers select a residential option in order to punish a child or remove the problem in the most expedient way. For this reason, mental health professionals must always act as both facilitators and gate keepers for referrals to residential treatment services and, occasionally, obtain the necessary legal backing to make a referral in the face of resistance from both the child and the caregiver. The point we wish to make, however, is that a residential service is more likely to be effective when it is allowed to work cooperatively with community caregivers and where, as much as possible, the child can continue to pursue an active role in the community.

From a planning point of view, this approach to the use of residential treatment would require some change in attitude on the part of service providers and the community in general. Effective coordination and accountability structures would be necessary to bring about an integration of the various services contained within a single plan. Last, but by no means least, funding mechanisms would have to be established that cut across traditional jurisdictions thereby ensuring that the necessary services were, in fact, paid for. In our view, all of this would be worthwhile if it served to prevent children from becoming 'locked into' residential programs, integrate residential services with community services and increase the likelihood of using residential services as preferred options rather than institutions of the last resort.

The Least Restrictive Alternative

In its original form, the 'least restrictive alternative' concept was used to protect citizens from governments pursuing legitimate purposes by restricting individual liberties when other less intrusive means could be expected to achieve the same results. The application of this principle to the field of mental health has been general and widespread, although the interpretations and applications have been extremely varied. For the majority of observers and commentators, however, the use of a secure residential facility is regarded as being the most restrictive service while regular community based or out-patient services represent the least restrictive end of the continuum. While these beliefs appear to be intuitively valid, they also represent a grossly over simplified perspective.

Freedom and restriction are not simply determined by the nature of the physical environment. We have experienced many children in residential centers, for example, whose freedom of thought and action far exceeds that which they have experienced in their own homes. By the same token, freedom defined in terms of available options, may be enhanced by the transfer of a child from a group home to a detention facility. Further complications arise when the dimension of *time* is added to the equation. Is it more restrictive, for example, to place a child in a residential treatment center for three days than to engage the same child and family in three years of weekly out-patient psychotherapy? In our submission, the term "freedom" is better defined as a state of mind rather than an environmental circumstance.

Predictably, this notion leads us to the conclusion that, where it is reasonably possible, the determination of the least restrictive alternative should be left up to the client i.e., the child or the caregiver. In this sense, it becomes part of the broader decision making issue discussed in the previous section. Where restrictions are externally imposed for the protection of others it might still be possible for the child and/or the caregiver to exercise choices, albeit within a limited range of options.

The client-centered approach advocated here does become problematic in situations where neither the child nor the caregiver are deemed to be competent in making decisions about the degree of physical restraint imposed. In this event, some 'advocate' must be designated to make a decision in the child's best interests. In our view, this should not normally be the role of the mental health practitioner. Rather the responsibility should be delegated to an individual holding some legal guardianship status. In the case of involuntary admissions or commitals to secure facilities, the rights of the individual child are probably best protected through some form of judicial process, combined with mechanisms for appeal and review. We believe that such provisions best serve to protect the client and the practitioner, as long as their wishes and opinions are given full consideration in the decision making process.

We find the determination of competence to be a particularly complicated issue. In this area, it is apparent that clinical considerations and legal standards are not necessarily complimentary. While we might accept the argument that a clinician is often in the best position to determine whether or not an individual is able to understand the nature and implications of the judgements being made, we also see many potential difficulties associated with this type of clinical responsibility. In the first place, not all clinicians will use the same set of criteria in coming to a conclusion, making it very difficult to establish effective accountability mechanisms. By the same token, those affected by such decisions may be at a loss to understand why the judgement was made and be in no position to offer a challenge. From a constitutional perspective, it seems that a judgement of incompetence removes fundamental decision making rights and this should not occur without judicial involvement. In this regard, we are inclined to agree with John Parry (1985);

> The judge first determines whether the disabled person is incompetent according to the legal standards set out by the legislature and, if so, decides who should act as the substitute consent giver. Later, the judge must review the treatment or care decision by the subsitute and determine whether the proper decision making standards and processes were followed, including whether the decision was based upon the proper medical information and reasonable attempts made to ascertain the patient's or client's preferences.

Normalization

The term 'normalization', popularized by Wolfensberger (1972), has generally been interpreted to mean that any direct intervention in the lives of individuals should respect and mobilize the normative influences of community life. In this sense, it is closely related to the principle of the least restrictive alternative. For our purposes, we have stretched the definition to encompass our belief that a children's mental health service should always be directed toward promoting the development of the child within the contexts of the family and the community, regardless of the particular treatment modality in question. While this principle does imply some idealized notion of community life (i.e., one that serves to support psychological and emotional well-being), it also suggests that primacy should be given to the experiences and perceptions of the service recipient.

Within the framework of service delivery, the concept of normalization can be applied across the entire services spectrum, regardless of the degree of physical restriction involved. While it would be a challenge to normalize a secure treatment environment, for example, the task might be no more difficult than attempting to modify the structures and processes within a highly dysfunctional family. In our submission, the two principles should work together such that, once the least restrictive alternative has been identified, the issue of normalization should be considered in terms of the specific needs of the particular client.

From our perspective, the normalization of services also emerges from an individualized, needs-based approach to treatment. By giving full consideration to the individual child within the family and the community, the practitioner attempts to take the perspective of the client in understanding the client's everyday life world. The clearer and more accurate the picture becomes, the more the structures and the processes of the client's environment can be mobilized in the course of treatment. Where deficiencies are identified, such as those arising from the absence or inadequacy of primary relationships, remedial action can be taken, but always with the client's perspective as the ultimate point of reference. While practitioners might continue to make idealized or theoretical judgements around the needs of children, families or communities, such judgements should always be assessed against the standard of subjective experience. In this regard, we are coming to recognize that the quality of primary relationships are more important than any standardized picture of what a family should look like; that some deviations from the 'norm' should be cherished rather than sanctioned and that playing hockey is not a necessary condition for male childhood status in Canada.

Amidst protestations of 'Who can be against children?' too few people are *for* children when it really matters.

M.W. Edelman.

David Mangurian

4. ACQUIRING RESOURCES

Within government services, there appears to be a tendency on the part of planners to base new initiatives upon new funding commitments. While we acknowledge that resources and services are inextricably linked, we also believe that the use of this strategy alone tends to stagnate systems and stifle creativity. In this section, we are more concerned with what can be done to bring about change within the existing system recognizing, of course, that increased funding would probably allow any program operator to do things that much better. To this end, we offer the following suggestions for acquiring the necessary resources to develop and operate a spectrum of mental health services for children and families.

The Community as the Primary Resource Pool

Throughout this paper, we have identified the community as the arena in which most mental health issues are identified and resolved. Our mental health standards are essentially community standards and the resources necessary for attaining these standards are, for the most part, contained within the community itself. We have emphasized the role of a children's mental health system in educating, supporting and assisting community resources in meeting the ongoing mental health needs of young people and their supportive networks of caregivers. For us, this is no fuzzy 'motherhood' polemic. We firmly believe that mental health planners should go out into the communities they seek to serve and identify the resources that might be effectively mobilized in an all out effort to make the psychological and emotional well-being of children and adolescents a community priority.

Like most other areas of human endeavor, maximum benefits accrue through a carefully thought-out plan of attack. As a point of departure, it seems that many of the most complex problems have been successfully resolved where problem solvers begin by examining that which is already staring them in the face. The use of such a strategy has created more than one "genius". Applying this principle to a mental health framework, we might begin with the proposition that the mental health client is, potentially, a mental health resource. Certainly, by empowering such service consumers we might expect them to become more demanding and discriminating both in the use of services and in advocating for those conditions that promote emotional and psychological well-being. Although we have no research evidence to support the contention, we would not be surprised to find that reformed smokers have been highly influential in bringing about reformed standards of behavior and promoting prohibitive legislation. It is also possible that, by encouraging clients to become actively involved in prevention and promotion at the community level, mental health professionals will be adding another dimension to the treatment process. Clearly, there is nothing anti-therapeutic about bringing people out of the closet, encouraging them to take action on their own behalf and inviting them to engage in activities for the benefit of others.

In the course of their everyday lives, mental health workers, social workers, public health nurses, school teachers and other human service professionals are consistently coming into contact with concerned individuals whose support might be co-opted on a case by case basis. The chances are that such individuals continue to care, even after their commitment to a particular case has run its course. Such individuals are resources that could be effectively mobilized within a community mental health system. We have also identified a number of community organizations and groups that take on a general mandate to provide personal services to their members and to the community at large. These include service clubs, trade unions, fraternities, recreational associations, etc. In large

communities, there appear to be many organizations that are literally looking for things to do to improve the quality of social life. In this regard, we consider children's mental health to be a particularly worthy cause. In our experience, many commercial organizations are also more than ready to offer expertise and financial support for community initiatives and there are a wide variety of Foundations already committed to the cause. In many larger communities there are existing advocacy groups that take it upon themselves to speak back on behalf of disadvantaged or disempowered citizens. In some cases they do address the needs of children and could readily be brought in to a concerted mental health scheme. In a collaborative framework such groups should be viewed as contributors rather than commentators and valued for their efforts, rather than being feared for their challenges.

In order to effectively mobilize these kinds of community resources, the planners and operators of children's mental health services should not sit back for others to come to them with challenges or offers of support. In our view, they should take the step of moving in and providing leadership. They should make sure that the community remains as informed as possible about mental health needs and about the performance of the services designed to meet those needs. They should systematically survey the community, on an ongoing basis, in search of new resources and actively develop systems through which individuals might collaborate and become mutally supportive. They should enhance their own profile as members of the community and promote the cause of childrens mental health through creative uses of the media and other vehicles of public communication. To make all of this possible, their political and bureaucratic leaders must finally understand that these activities are fundamental to the position and not merely extras thrown in above and beyond the call of duty.

Professional Services

Administrators of human service organizations are generally committed to the cause of survival for their particular program or agency. The best way to achieve this is to control as much of the potential 'market' as possible and establish the strongest possible funding base. In this context, regional service planners are often perceived to be necessary evils who should facilitate the required funding with the minimum of expectations and constraints. For the most part, they are considered to be representatives of government and not representatives of the community. Experience suggests that it is often easier for individual program operators to mobilize community action in opposition to decisions made by government planners than it is for such planners to effect the actions of program operators in meeting community needs.

In our framework, system planners should operate between the community and the service delivery system. This means that they must first establish their role in relation to the community and then begin to encourage service providers to become involved in identifying needs and designing the appropriate modalities of service. With the support of a community, it is then possible for planners to play a credible role in encouraging the various agencies and services to make the necessary adjustments with funding being used as the ultimate contingency. As we suggested earlier, however, it is critical that this process take place in a collaborative and supportive manner.

One of the perennial problems across Canada is that many of the services directed toward children's mental health are not funded through a mental health system. Some of these programs may draw their money from child welfare systems because of federal-provincial cost sharing arrangements, while others provide services within the juvenile justice system. True to the nature of Public Service, these jurisdictions are not readily prepared to give up

'their' resources or transfer 'their' funds in the interest of 'another' service area. This does not mean that a children's mental health service planner must sit in a state of impotence waiting for the bolt enlightenment to strike higher up the administrative ladder. In promoting the cause of children's mental health within the community and by establishing the standards for service delivery, two compelling forces are unleashed. In the first place, public demand is known to be one of the most effective political weapons. In the second place, the establishment of standards for the delivery of mental health services to children and families makes it possible for the designated mental health service to become involved in monitoring and accrediting those services that aspire to attain such standards. Services that are not duly accredited in this way, can quickly come under the scrutiny of the professional community and the public in general. In some cases, it may not be necessary, or even desirable, for accredited programs to be directly operated by the designated children's mental health system while, in other cases, it may be more expedient for the service to be provided directly by the mental health service with the costs charged back to the other jurisdiction.

We are suggesting here that the planners of children's mental health services should go out and identify the appropriate professional resources in much the same way as they might assess the availability of community resources. While it is not necessary for them to 'own' all of the services required in the development of a comprehensive system, it is still possible for them to establish the foundations for collaboration and integration through a community supported mandate, along with the establishment of standards and accreditation and the development of cross-jurisdictional funding mechanisms.

This obviously raises the question of whether services should be provided directly by those responsible for the planning or whether such services should be contracted out to privately operated agencies and individuals. In this regard, we take the position that, while some essential services may be more appropriately delivered by government jurisdictions, service planners are better able to represent the identified needs of the community when they are not, at the same time, the primary service provider. Without effective community linkages, however, this situation can rapidly become one of abandonment and neglect.

Non-Traditional Approaches

In our experience, mental health professionals tend to be bound up in traditions and practices, ritualized in graduate schools and protected through professional associations. A great deal of effort and energy appears to be directed toward maintaining these approaches in the interests of professional integrity, thereby emphasizing the differences of practice rather than the similarities of purpose. While we support the general principle of disciplinary development, we also believe that a commitment to interdisciplinary practices should be a fundamental feature of a children's mental health system.

Looking beyond the limitations of professional boundaries, it is apparent that many other service strategies and human resources could be available to the system without significant cost increases. Although there will always be a need for direct one-to-one psychotherapy, for example, there is little evidence to suggest that most of our scarce professional resources should be concentrated in this particular activity, however satisfying it might be for the practitioner. On the other hand it is unlikely that, by redirecting a few professionals into innovative program designs, radical changes would be brought about. Here we would look toward other individuals such as child care workers and public health nurses to provide the additional ther-

apeutic manpower, with psychiatrists, psychologists and social workers available to offer direction, supervision and support. With this type of resource configuration, it would be possible for a mental health service to move directly into the community with school programs, home support services and one-to-one counselling opportunities. In addition to these possibilities, we are confident that such action oriented teams could generate a multitude of differential service options matched to the particular needs of the community.

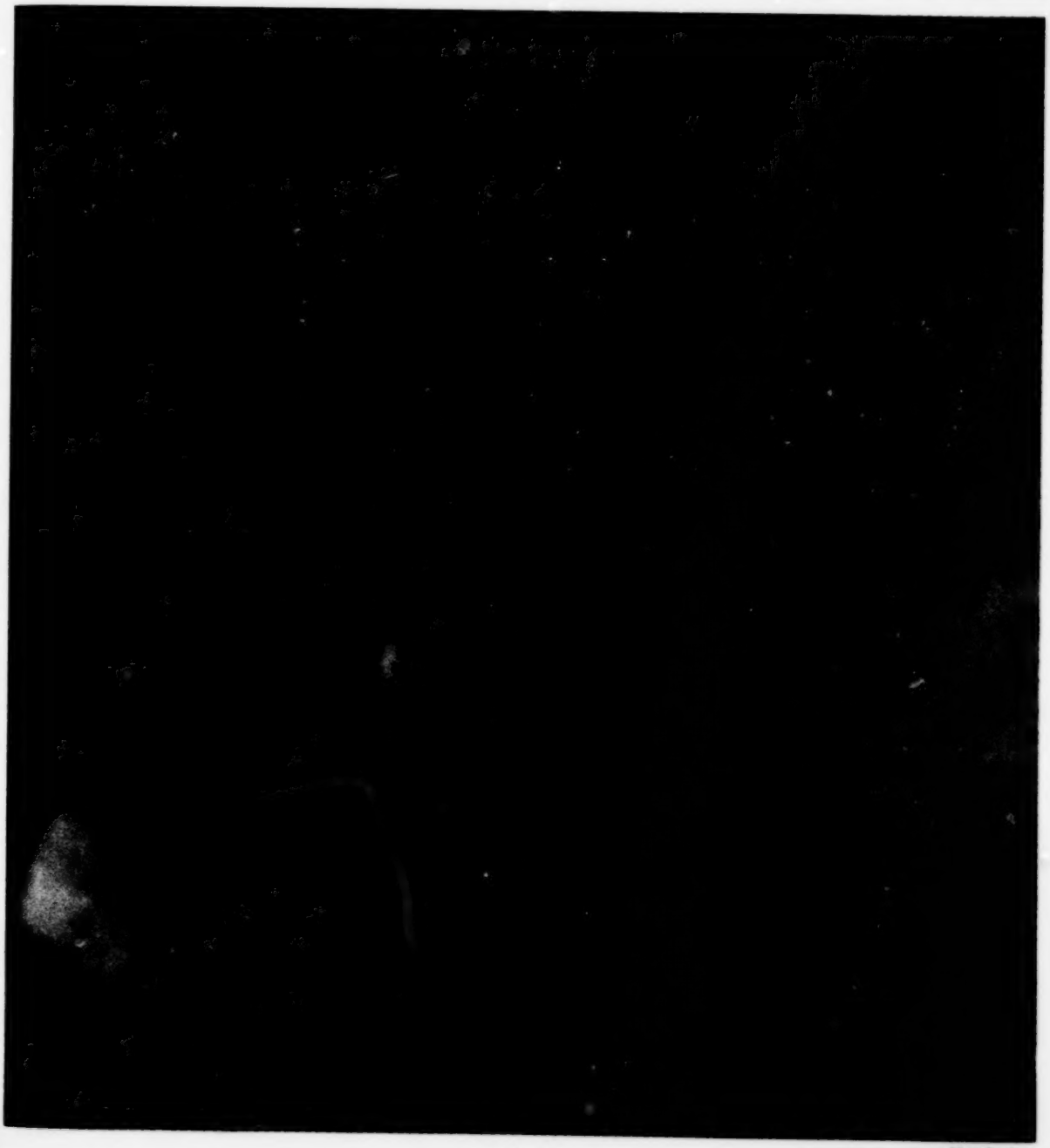
In developing such programs, there are obvious financial costs to be considered. Where no funds are readily available for these initiatives, the necessary dollars must somehow be gleaned from existing allocations. Here, the program planner must play the role of entrepreneur ready to sell a service, rather than the role of bureaucrat striving for a share of the public purse. This begins with identifying who is likely to benefit from the service being planned. Obviously, the direct service recipient is the primary beneficiary but, in many situations, these consumers do not have the financial resources to support the service. In all cases, however, there are other potential beneficiaries who may be already expending funds in a futile attempt to address the problem. In the public service domain, school systems, child welfare agencies, correctional services, daycare organizations, medical jurisdictions, etc., all find themselves struggling to address issues of children's mental health. A mental health system that can provide effective services in these areas offers both relief from human distress as well as an opportunity for increased cost-benefit. Such savings, then, become new sources of funding for mental health initiatives.

While it might be radical to suggest that public service organizations should contract services out to one-another there are many precedents in Canada and across North America that support the viability of such a concept. Given an attitude of collaboration across the various jurisdictions involved, there are a wide variety of joint funding, charge-back and fee for service mechanisms that could be developed to make such a system work without the constant demands for more funds to be injected into the various systems.

In our view, negotiated service arrangements among service delivery systems would also create a variety of secondary spin off benefits. Since service providers are closer to service consumers than high level policy makers, there is a greater likelihood that the actual needs of the community would be addressed. Secondly, such arrangements would serve to underscore and reinforce the spirit of collaboration and collective accountability. Finally, such arrangements would provide mental health planners with an ideal vehicle for drawing others into the children's mental health cause.

Beyond the public service sector, there may be numerous other groups and organizations that have missions and mandates related to the emotional and psychological well-being of children. They also should be regarded as potential sponsors for particular types of mental health services. By making use of such potentials, planners would not only contribute to the efforts to reduce government spending, they would also be taking a direct step toward making children's mental health a community responsibility.

There is room in the halls of pleasure
For a long and lordly train
But one by one must we all file on
Through the narrow aisles of pain.
Ella Wheeler Wilcox.



Albert Squillace

5. ORGANIZING AND MOBILIZING RESOURCES

The Organizational Context

The ultimate organizational challenge is one of developing a coordinated continuum of mental health services for children and families that effectively addresses the range of identified needs within a defined community. Regardless of the resources available to the system planner, the task is unquestionably monumental.

In our opinion, the astute planner must begin by recognizing that the most sophisticated system design will only be effective to the degree that, (1) participants share a commonality of purpose and (2) participants have experiences that, for the most part, match their hopes and expectations.

1. A commonality of purpose. Sponsors of mental health services may have many reasons, both overt and covert, to account for their benevolence. Governments, as the most prolific sponsors in North America, obviously have agenda that are essentially political in nature. This is not meant to imply that governments are not well-meaning in their efforts to improve societal conditions, only that they tend to respond to those issues that are of most concern to the franchised electorate. Clearly, this does not include children who must rely upon more influencial citizens to speak on their behalf. Philosophically, democratic governments tend to operate on the assumption that individuals are free to choose their destinies and may be held responsible for their actions. Hence, exhortations on behalf of the downtrodden or disadvantaged are not always favorably received.

Bureaucratic jurisdictions are primarily established to serve governmental purposes. Standing between the politicians and the electorate, they are the shop window of government activity and the servants of the community. From this position they are unable to take on their own definitive sense of purpose. Hence, their primary mandate is one of administration and their purposes are bound up in protecting the integrity of the structures they create. Since governments and policies are constantly changing and public opinion is often unpredictable, the quest for security and survival is often reflected in an overriding concern for establishing clear jurisdictional boundaries and, wherever possible, extending territorial parameters. Philosophically, it is extremely difficult for a government department to take any stand since it must constantly walk the tight rope between the policies of the government and the reactions of the public.

Service providers also embrace a fundamental commitment to survival and, in many cases, expansion. In this regard, their primary purpose is to obtain the necessary resources to enable them to carry out their own particular sense of 'mission'. Philosophically, they represent a wide range of perspectives on the nature of the human condition and the action that needs to be taken in promoting personal well-being. In spite of differences, disagreements and challenges that occur among service providers, however, planners would be well advised to work on the assumption that all agencies, groups and individuals working in the field do, in the final analysis, share a common sense of commitment to the individuals and communities that they set out to serve. While this might sound like an 'apple pie' statement, we are concerned that, with the advent of the commercial ethic within human services, this motivational foundation will be eroded in the interests of efficiency, cost-effectiveness and profit seeking.

Consumers of mental health services do not necessarily share a common sense of purpose. While we might assume that their basic intent is to get help for their 'problems' this is probably a gross over simplification. Some are undoubtedly coerced into the system through the threat of sanctions or the compelling influences of others. Their purpose may be to go through the motions, with no sense of commitment to the process. Others may be seek-

ing justification for their actions, or support in attributing their problems to circumstances beyond their control. Then there are those who would like to absolve themselves of all responsibility by transferring the problem to the professional practitioner. Philosophically, they may be as varied in their world views as the problems they present.

Finally, there are the social reformers, philosophers and advocates who generate and promote visions of a new society. As interested observers of human service systems, they can become powerful forces in stirring up public opinion and exerting political influence to either pressure or support particular service providers. Their purpose is usually to bring about some form of predetermined change in the system and their philosophies are generally known and explicit. These comments do not of course, refer to those individuals and groups that carry a legitimate social mandate to monitor services and advocate on behalf of recipients. Nor are they directed toward other individuals and groups that simply express a common concern for others by offering support and suggestions toward improving the quality of life.

In mobilizing resources toward a coordinated children's mental health system, the various interests identified above, along with many others, must be taken into consideration. This is not to suggest that they should be all addressed and reflected in the system as it emerges.

While we might be accused, at this point, of being overly lofty or abstract in our thinking, experience suggests that all human services must ultimately face these kinds of influences and that to consider them before hand is nothing less than pragmatic. What needs to emerge from such considerations is a broad statement of philosophy and intent that can be shared and negotiated with the primary participants in the system, as well as the community at large. This statement should be built around areas of agreement, without placating or disguising issues that remain controversial. Kept in sight, these arenas of debate can provide much of the energy needed to bring life to the system. Closetted away, they may well become persistent sources of resentment that generate subversive activities in a conspiracy of silence.

2. Meeting Expectations. Obviously, no system can expect to meet all of the varied expectations that emerge from this complex network of interests and purposes. In the early planning stages, the most dangerous mistake may well be one of trying to accommodate too many in the hope of keeping everyone happy. In our opinion, one of the most destructive features of the mental health movement in general is that its level of performance has been well below the level of expectation and aspiration. The 'curative' model has not cured and the 'preventative' model has not prevented, at least to the degree that many of the protagonists have promised or predicted. Hence, sponsors have questioned the efficacy of their expenditures, consumers have become suspicious about the ability of practitioners to help, communities have come to doubt the commitment that systems make and practitioners have had to face the reality that they have no magic wands to wave over the depressed, distressed and disadvantaged members of society.

Once a broad philosophy and statement of intent has been negotiated, we suggest that the architects of a children's mental health system adopt a simple formula in operationalizing the goals and objectives of service delivery. This involves identifying what such a system can be expected to achieve. It can, for example, establish a broad spectrum of differential services. It can create effective coordinating linkages among service components. It can move the focus of services from residential to community based programs. It can establish mechanisms to facilitate community input and feedback and it can provide services in a cost efficient manner. From this type of realistic base, it is possible to

identify those things that the service might hope to achieve. These might include goals such as creating a more informed community, reducing the prevalence of mental health disorders in young people, keeping children out of child welfare systems and hospitals or mobilizing community resources toward children's mental health issues. Finally, a clear statement should be made about what such a system should *not* be expected to achieve. This might involve exploding some of the myths that have created so much disenchantment in the past. The system will not be able to 'cure' the mental health problems of the community. It will not stop children and adolescents from becoming a threat or an embarrassment to their parents and it will not successfully handle all of the cases that have failed to respond to other service options.

Organizationally, we have already referred to a number of principles that should serve to guide the planning process. Given our particular orientation, planners should keep in mind that the emerging system of services is primarily intended for the benefit of its user's. Hence, every effort should be made at the outset to ensure ease and universality of access. Within the scope of available resources, clients should be able to choose from a range of high quality service options. As much as possible, services should be organized to tailor their assistance, or interventions, to the identified needs of children within the contexts of the family and the community. Finally, each service should be sensitive and responsive to consumer feedback in the ongoing evaluation and development of its programs.

Having stressed these points again, there are a number of issues that we consider to be particularly significant in developing an organizational design. The list presented here is by no means exhaustive and is in no way intended to represent a planning formula. On the contrary, it is our conviction that particular organizational structures and processes should emerge from the wishes, objectives, needs and resources embraced within a given community.

Establishing a legal mandate

A legal mandate to provide a mental health service to children and families is not simply a regulatory framework that prescribes what must and must not be done. Carefully considered, and skillfully articulated, it can provide a highly facilitative foundation that promotes the quality, accessibility and coordination of services. At the outset, it can provide assurances to the community that such services, will in fact, be provided and that both clients and providers will be given some protection in law.

To maximize the potential of a legal mandate, we believe children's mental health should be embodied within a separate set of provisions that recognize the special needs of children and young people. As much as possible, such legislative provisions should be closely linked to other legislation that directly or indirectly, impinges upon the lives of children. Ideally, we would opt for an omnibus legislative package that addresses the status of the child in society, from the Charter of Rights to Provincial Acts. This would exemplify, in a legal way, our principle of attending to the needs of the total child within the contexts of the family and the community.

The principle of ease and universality of access, raises the perennial issue of 'consent'. In this regard, we have already suggested that, as much as possible, children and adolescents should be directly involved in significant decisions affecting their lives. We also recognize, however, that parents and caregivers have specific rights and responsibilities in making decisions on behalf of the children in their care. In attending to the many dilemmas contained within this issue, a legislative mandate must specify the

conditions under which it is possible, and necessary, for a child to consent to a particular form of mental health service; the conditions that make it necessary for a parent or guardian to give consent and the conditions that allow, or prescribe, the consent of a third party.

Given the complexities involved, the Children's Mental Health Project has developed a comprehensive paper on this issue. Since this paper is readily available the details of the discussion will not be included here. In brief, however, this paper recommends that parental consent only should be required for the provision of residential and non-residential mental health services for children under 16 years of age, but that a child who disagrees with this decision should have access to a third party review. It also suggests that involuntary placement in a secure treatment facility be subject to a separate set of provisions from those governing adult commitals to mental hospitals.

More appropriate to the context of the present discussion, we are proposing that children's mental health legislation, along with its associated regulations, should address the quality of services and the manner in which such services are organized and delivered. To exploit this potential to its fullest, mental health officials would be well advised to involve their legal advisors and legislative planners at all stages of the developmental process. If legislation is to be facilitative it must follow from the general orientation, intent and design of the system, rather than be established as an a priori obstacle to be confronted and overcome.

Establishing Standards

We have already stressed the importance of standards as a means of identifying and acquiring resources appropriate for a children's mental health service. From this perspective they are also essential means by which services can be monitored, reviewed and accredited. More importantly, however, they provide the assurances to service sponsors and consumers that a predetermined quality level is being maintained.

In identifying the most appropriate standards to be incorporated into the system, there are many professional and organizational models to choose from. While those that pertain to the self-governing professions should be automatically included, the broader models designed by accreditation agencies and organizations should be carefully scrutinized to assess their 'goodness of fit' with the particular ideals of the system in question. In accordance with our own ideals, we would suggest that the quest to develop appropriate standards begin at the direct service delivery end of the organizational pyramid and then progress systematically through the various structural levels.

It is important to emphasize that generic standards for mental health practice must be supplemented with specific service standards relating to particular types of programs. As a general rule, the more intrusive the intervention, the more important it becomes to identify clearly established criteria for program operation. In the area of residential treatment, for example, it is obvious that standards must address practices that impinge upon the client for 24 hours a day and 7 days a week. In this section, we make no attempt to specify or analyze all of the differential standards necessary for the operation of a comprehensive mental health system. Rather we are concerned with the issues involved in standard development. We suggest three areas in which the standards of a children's mental health system should be clearly defined.

1. Professional Competence. Here, we are concerned with the professional qualifications, roles and practices of practitioners involved directly in service delivery. The development of standards in this area should address the following:

a. The degree to which a given profession is self-regulating and able to practice autonomously in areas specified in that profession.

b. The specific unique contributions of each particular profession (e.g., in assessment and treatment) along with the limitations prescribed by the particular professional boundaries.

c. The services that could be provided based upon academic qualifications alone and those which require additional training and supervision.

d. Those services that can only be provided by professionals in consultation with professionals from other disciplines.

e. The situations in which multidisciplinary assessments and interventions are optional, desirable or mandatory.

f. The acceptable options for service delivery where appropriately qualified staff are not available.

2. Service Delivery Issues. Here our concern is with specific delivery standards in the areas of assessment, diagnosis, treatment planning, treatment implementation, follow up and consultation. In the direct delivery of mental health services the following issues need to be addressed:

a. Given that mental health service programs are typically multidisciplinary, how should the roles of each discipline be circumscribed?

b. Should multidisciplinary approaches be mandatory in certain cases or programs?

c. Should elements of a children's mental health system consider the use of a standardized assessment format that could be administered across disciplines?

d. What criteria should be established for the use and interpretation of particular diagnostic procedures? Diagnostic skills and abilities cannot simply be assumed by the academic qualifications of clinicians.

e. How can service standards ensure that treatment strategies are appropriately linked to need assessment and that particular intervention approaches are predicated upon an anticipation of treatment outcomes.

f. Apart from clinical judgement, should standards be in place to assist practitioners in determining when to make alternative referrals or seek particular kinds of consultation?

g. If specialized expertise in children's mental health is a relatively rare commodity, should standards establish the degree to which that expertise is shared through consultation activities?

3. Manpower Requirement Issues. In this area, we are concerned with general manpower requirements in accordance with the identified nature, needs and objectives of the program. As examples, the following issues would need to be addressed:

a. Should there be definitive standards to determine how many clinicians with particular qualifications should be available to a given population? In this regard, some studies estimate that 10 to 15 percent of all children will need some form of mental health intervention before adulthood and approximately 25 percent of this group will require highly specialized intervention.

b. Given the tremendous variation across programs, populations and regions, is it necessary to develop differential standards for each category?

c. Should manpower standards be modifiable in the light of available resources? The response to this issue may result in differential standards between rural and urban regions, or the denial of mental health services in certain geographical areas.

Obviously, in this section, we have not attempted to develop a definitive set of standards for practice in the area of children's mental health. As part of the task, however, the Children's Mental Health

Project has reviewed a broad range of standards pertaining to child welfare and mental health practice. For the most part, we believe that the standards across service delivery areas should be as complementary as possible and that certain baseline requirements should be consistent across agencies, systems and jurisdictions dealing with children. In our view, however, the specific standards pertaining to children's mental health should leave no doubt about the intent of the system to provide a range of high quality professional services.

Establishing Practitioner Autonomy

In our earlier document, *Service Philosophy, Principles and Guidelines*, we emphasized the well-being of practitioners as a critical factor in ensuring a humane and effective approach to service delivery. Our essential proposition is that, in a *health* oriented system, consideration must be given to the on-going mental health needs of those who actually provide the service on the frontline. While this is true of all participants in a social service, it is particularly important in the case of people who use their own 'selves' in attempting to provide support and assistance to others experiencing mental health difficulties. Essentially, the needs of the practitioner are no different from those of the client addressed earlier. They need to be involved in a stimulating, trusting and caring environment that supports their sense of esteem and autonomy. Their experienced level of personal security, along with their day-to-day physical needs, are issues of constant concern to the enlightened administrator.

Obviously, the key to providing an appropriate systemic environment is found in the attitudes of managers, planners and policy makers. Beyond this stance, there are many things that can serve to create the conditions that translate these attitudes into action. Effective channels and vehicles of communication, up, down and across the system, support autonomy by providing information about the work context along with opportunities to influence the course of events. Competent and credible supervision directed toward enhancing performance rather than control, contributes to both personal and professional competence. Direct interactional, evaluative feedback on a regular basis offers constant opportunities for the enhancement of self-esteem. Clearly articulated and humanely administered personnel practices create a sense of security and self-determination. Ongoing interactional events such as case discussions, clinical rounds, seminars and special interest sessions, along with varied work opportunities, generate both personal and professional stimulation. Pleasant and comfortable physical environments as well as recreational and support options, contribute to a general feeling of being valued and cared for.

The list is endless and none of the above suggestions should be novel to the concerned administrator. The fundamental revelation lies in the fact that such obvious ingredients are so often glaringly absent in human service systems and organizations. Presumably, they operate on the assumption that practitioners must be quite different from the clients they serve and that their needs are of little or no significance. The price paid for this stupidity is readily apparent in such indicators as rapid turnover, burn out, disenchantment, rigidity, undermining, resentment, squabbling and, ultimately, poor quality service. Of course, these problems can always be attributed to the pressures of the work, the demands of the clients, the consequences of over involvement and a host of other rationalizations that have come to characterize the helping professions. We, on the other hand, believe that a practitioner whose own personal health needs are being met can continue to be completely "with" the client and that this state of "presence" is an energizing, rather than a debilitating experience.

Case Management

A comprehensive children's mental health sys-

tem that embodies the principles discussed in this paper may be expected to conduct its business in conjunction with a wide range of professionals practicing both within the system and outside the system. Mobilizing these resources around the specific identified needs of clients is, perhaps, the most critical and complex administrative challenge. The issue of case management was addressed in detail in the original discussion paper generated by the Children's Mental Health Project. At this point, we will limit ourselves to a brief overview of what we consider to be the essential characteristics of effective case management.

In a practical sense, a case management mechanism is the vehicle through which the collective commitment and commonality of purpose is exemplified by practitioners, regardless of their professional or jurisdictional affiliations. This requires a clear articulation of their roles and responsibilities in the assessment of needs and the implementation of strategic treatment plans. Ultimate responsibility must rest with one primary practitioner who can be held accountable by both the client and the agency that carries the formal mandate. In some cases, this individual may represent the children's mental health system while, in other cases, a mental health worker may be providing services to a client engaged with some other organization, agency or jurisdiction.

One of the most frequent and troublesome issues arising from the arena of case management is the appearance that one practitioner is in a position to direct, or even supervise, professionals from other areas and disciplines. In our view, this perception is not valid where a firm commitment to collaborate has first been established. Regardless of who is identified as the case manager, each professional involved is responsible to her or his own organization and professional code for the nature and quality of the services she or he provides. In this regard, it is critical that the case manager be kept fully informed about these services and the responses of the client. By the same token the case manager is responsible for making sure that this information is made available to the other practitioners involved, in order to ensure that the various services are delivered in a compatible way, considering the client as a total person and not as a fragmented object. In all of this, it is the specific task of the case manager to steer the overall direction toward the goals outlined in a mutually agreed upon plan of care and treatment. For this to be effective, no involved practitioner is at liberty to make unilateral decisions that effect the overall course of treatment without first consulting the case manager and, where necessary, other members of the treatment team. In the event of disagreements among team members with respect to this plan, the case manager should be obliged to call a halt to the process until the problem has been resolved. For practitioners to be working in non-complementary directions, the consequences to the client, whether child or family, are clearly damaging.

The mechanisms for resolving disputes may vary from situation to situation. In some cases, the primary practitioner may decide to change membership in the treatment 'team'. In others, some form of arbitration may be built into the system. Alternatively, it may be necessary for a higher supervisory level within the system to become involved. Wherever possible, however, we believe that disputes or disagreements should be addressed within the team itself. In this regard, there is no satisfactory substitute for direct face to face interaction among team members.

Given our philosophical perspective, the significance of a case management system cannot be over emphasized in attempting to deliver mental health services to children within the contexts of the home and the community. To work effectively it requires not only a commitment to collaborate on the part of practitioners but also a commitment on the part of their various organizations to allow

services to be coordinated. This includes a willingness to share resources and information in a common concern for the total well-being of the individual client or family. As we have suggested elsewhere, "Zealous protection of divisional boundaries, striving for relative professional status, over protection of budgetary delinations and exclusive 'ownership' of particular client characteristics are distinctly hazardous to the health of the client, practitioner and the system as a whole".

Establishing Funding

Ultimately, we must face the reality that the efficacy of a children's mental health service will depend upon the amount of money available, the individuals who control dispersement and the particular contingencies imposed. Since it would be unusual, and probably undesirable, for a government or other funding body to create all of the new dollars necessary to develop a system in its entirety, planners may have to examine a range of alternatives.

The most essential ingredient in the development of a funding strategy is the articulation of a well designed, comprehensive service delivery plan. The more that this design clearly addresses the needs of service providers and the community in general the more it will receive wide spread support and the more sponsorship will be a likely outcome. In our experience, simply throwing around concepts, ideas, or vague proposals for reform do not attract the attention of governments and other funding bodies. Individual program proposals may have popular situational appeal but the monies generated are rarely sufficient to affect the overall face of the service delivery system. For the most part, the major sources of funding need to know how things will fit together, how services will be integrated in a continuum of care and treatment, how such integration will contribute to a cost-effective system and how, in the broadest sense, the needs of the community will be more effectively met.

In the second part of this paper we will address funding issues specifically from a provincial perspective. At this point, we are primarily concerned with some of the more general issues involved in developing a funding strategy. Some of the available options have already been identified but we will include them again here as part of a general review.

Provincial Government Funding. In Canada, federal-provincial cost-sharing arrangements have been a critical consideration. In this regard the Canada Assistance Plan has been used as a primary vehicle for providing services for children with some form of welfare status. This does not normally include the provision of mental health services although it has been recognized that many of the children caught up in the welfare system have dire needs for such a service. It is also readily apparent that if such mental health services were available to these children and adolescents, without status requirements, many of them could be diverted from the unsatisfying experience of having to accept a welfare label that shifts the focus of control away from families and toward government officials.

While it is possible for child welfare agencies to 'purchase' mental health services, we do not believe that a child welfare or protection system should be used as a vehicle for accessing such services. Nor do we support arrangements whereby children with child welfare status are denied access to mental health services because of funding contingencies. Across the country, there are many examples where this approach has resulted in welfare services developing their own mental health programs under some other name. Operating outside the boundaries of the mental health system, these programs and facilities are not subjected to mental health standards of practice and are denied the opportunity of becoming part of the mental health com-

munity. Obviously, changes to the Canada Assistance Plan are called for and we would urge governments and system planners to collaborate and agree upon a new formula that would dismantle this anachronistic arrangement.

Given the level of funding available in a province for family and children services, there are a number of mechanisms that can be used to transfer dollars from other jurisdictions wishing to have access to a comprehensive mental health system.

The movement away from direct government services and the increased use of private organizations or individuals has increased the viability of *fee for service* arrangements. Through this mechanism, it is possible for a department to purchase mental health services for particular clients or populations. Where the service is provided directly through the mental health system, the service making the request would be appropriately billed. In cases where private practitioners are being used, the fees could be paid directly by the requesting service or via the mental health services system. In either case, the private practitioner or organization would be considered to be part of the overall mental health pool of resources.

Like fee for service, *time limited contracting* has many potential applications within the framework of a children's mental health system. Such contracts might be used by a mental health service to make a variety of private practitioners available to their clientele. Such contracts could also be developed in providing services across jurisdictions. One example would be in the case of services provided to juvenile correctional programs or facilities.

Where contracts are inappropriate for providing services across departments or regions, a system of *cost charge backs* could be developed which would allow children's mental health services to be provided by the most appropriate service provider without undermining the ability of the particular department or region to assume financial responsibility for its own clientele.

In the area of residential treatment, *per diem contracting* has clear applications. Such contracts could vary from purchasing a comprehensive service from an agency for a particular child to having a residential agency purchasing a mental health service for its particular program, also on a per diem basis.

In addition to the above options, we have already indicated that service planners should create and explore a wide range of innovative and creative options for which there may not be existing precedents. We are particularly enamoured with the unexplored potential in the area of *jointly funded* projects and programs. Such arrangements not only free up stagnated funds but also promote collaborative and coordinated effort.

For many proponents of the Welfare State, the very notion of *user fees* for human services is an anathema. From our point of view, it represents a challenge to the principle of universal access. On the other hand, we are drawn to the concept of mental health clients being in a position to 'purchase' those services that they require. Social philosophy aside, this comes down to the very practical problem of somehow putting power in the hands of those who are not able to afford the service in question, or must seek out the cheapest, rather than the most appropriate, option. Potentially, there are many ways of doing this without forcing our less wealthy citizens into the welfare arena or disempowering them with a cap in hand approach to the service provider. One option would be for a centralized provincial system in which the costs of all services provided are assessed on individual 'accounts' with users billed accordingly. Those unable to pay would then receive the necessary subsidization. While this would create the contro-

versy surrounding some form of means test, it would prevent the creation of a consumer class system providing differential services to the rich and the poor.

Community Based Funding. The availability of funds for mental health services will obviously vary from community to community and it is not our intention to amplify existing regional service disparities. On the other hand, we do believe that direct community support for children's mental health is an important concept that should be encouraged. System planners and managers do have a direct responsibility to ensure that services in each area meet the necessary standards but, in our view, there is no reason why individuals and groups in particular communities should not be able to add to the service through direct contributions.

There could be increasing variability in unique encounters between carer and client, a redirection of caring energy away from professional rituals and into direct responsiveness to people.

William Rhodes

Bruce Roberts/Rapho — Photo Researchers

6. ESTABLISHING LINKAGES

Organizationally, a children's mental health system must have some ultimate point of accountability. In a government sponsored service, this would logically be located within one of the departments already involved in the delivery of children's services and mental health services. The most obvious options are provided by Educational, Medical and Social Service jurisdictions. Ideally, the decision of where to locate this service would be based upon such factors as prevailing philosophy, existing resource configurations, established expertise in working with children and families, existing mandates, proximity to the clientele and the community, existing linkages with other jurisdictions and acceptability to the general public and professional community. We must acknowledge, however, that there are many more political factors that might impinge upon the decision making process. In the second part of this paper we offer some specific recommendations on this issue but, at this point, we will again restrict ourselves to general issues and principles.

Integration and Coordination

In our earlier discussion paper, we drew a distinction between an "integrated" model and a "coordinated" model of service delivery. In this schema the integrated approach places all the accredited children's mental health services under one administrative auspices with a single accountability structure. This jurisdiction would be solely responsible for providing the full spectrum of services, either directly or through contracts with other service providers. In order to achieve this, children's mental health resources operating within other departments or structures would need to be transferred and accommodated within the integrated network.

By contrast, the coordinated approach would give primary responsibility to one jurisdiction for developing the collaborative arrangements necessary to ensure that each community has access to a full spectrum of services that maintains a prescribed level of standards and operates with a collective sense of purpose toward mutally agreed upon objectives. In this framework, the selected jurisdiction would be directly accountable for the services provided by its own practitioners but not for the activities of those employed elsewhere. The mandate would be one of coordination, negotiation and evaluation with policy and planning direction established at the highest possible inter-departmental level. In this way, the various jurisdictions involved would agree to be coordinated and would, together, negotiate how the system should operate and direct their resources accordingly.

While many organizational purists might be attracted by the 'cleanliness' of the integrated approach, others might be concerned about the potential for developing yet another bureaucratic monopoly that would then become increasingly insensitive to needs existing beyond its own carefully drawn boundaries. Additionally, an integrated design would undoubtedly call for major surgical intervention in the anatomy of existing systems and this prospect may not be particularly appealing to the parties affected.

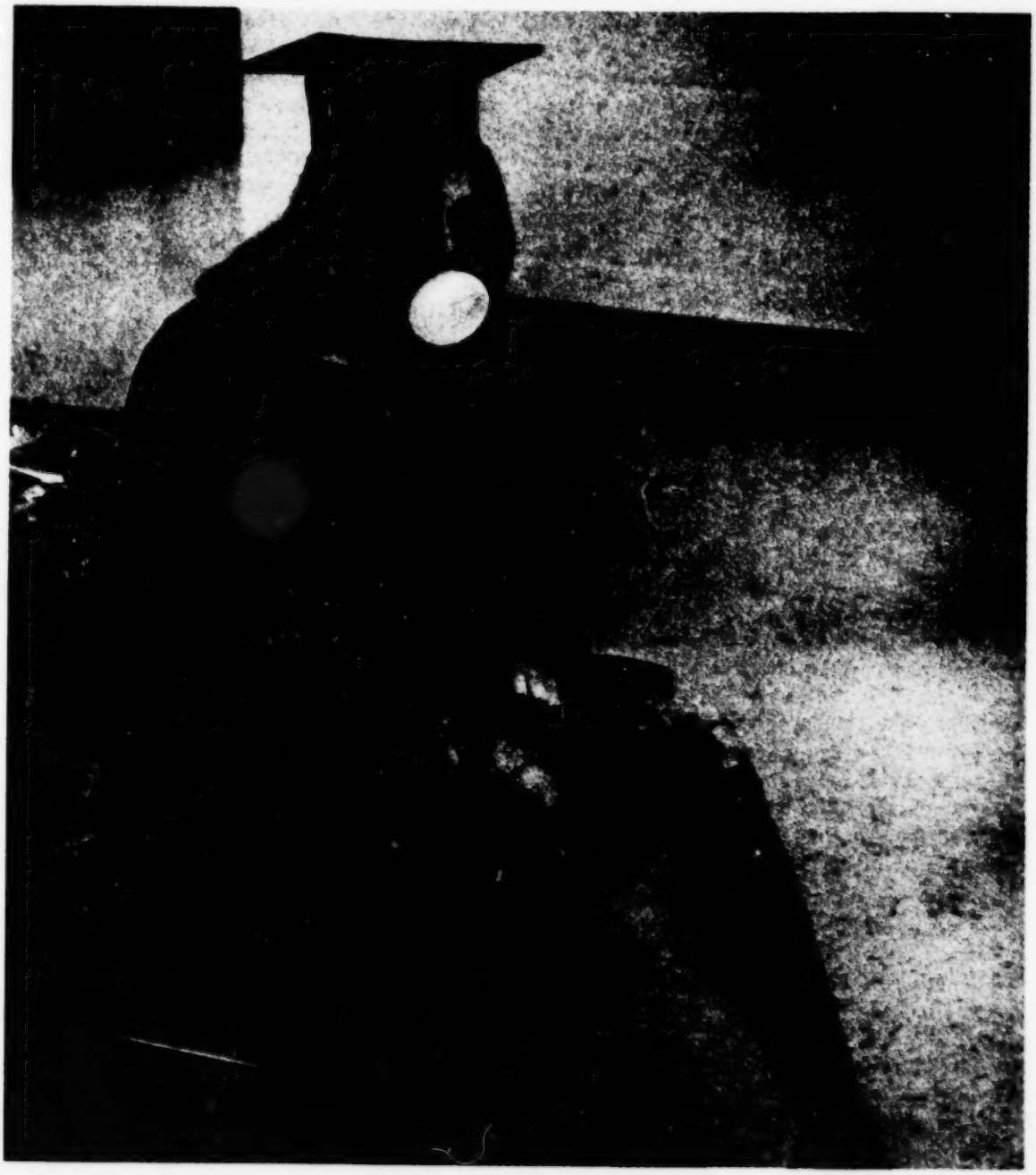
The coordinated model, on the other hand, represents a much more cautious, conservative but potentially more adaptive approach to the problem. Protagonists would probably argue that human services should be allowed to evolve at their own pace anyway in order to remain in constant touch with the variety of needs to be addressed. Antagonists would probably highlight the problems involved in trying to actually direct such a system and suggest that much of the energy expended in negotiating deals and resolving differences could, and should, be directed toward providing services to clients.

At this point, we prefer to sit on the proverbial fence, recognizing that any decision has to be taken within a particular context in the light of the particular objectives to be attained. Our primary con-

cern is that, one way or another, there must be effective linkages among those who provide mental health services to children and families in order to ensure universality of access, a fully coordinated spectrum of services, information sharing and dissemination and a commonality of learning.

Speech and writing are undoubtedly marvelous, but for this very reason they have a hypnotic and fascinating quality which can lead to the neglect of nature itself until they become too much of a good thing. Thus when 'the rule of Law' becomes absolutized and everything is done by the book or the computer, people call out in desparation for the intervention of a reasonable human being.

Alan Watts.



Jim Richardson

7. INFORMATION SYSTEMS AND EVALUATION MODELS

Although this chapter is relatively brief, this is not intended to imply that we consider the topic to be less significant than those discussed in previous sections. On the contrary, we firmly believe that no system of children's mental health services should be developed without a strong commitment to information systems and evaluation. In fact, this point of view is strongly implied in much of what we have had to say about needs assessment, developing strategies, acquiring and mobilizing resources and co-ordinating systems. Given the complexity and diversity of the technologies involved, however, our intention here is to clearly establish the need and leave the question of "how" to the experts.

From our perspective, the need for systems of monitoring and evaluation are self evident. The approach to service delivery suggested here necessitates the ongoing flow of information across many areas if planning, management and delivery are to be effectively conducted. This implies that all of the individuals and groups involved in the development of children's mental health services should be operating from the same informational base. A needs-based design demands that the system be sensitively tuned to the changing needs of consumers and the ability of service providers to meet these needs. From the practitioners point of view, it is also essential that provision be made for the generation of process and outcome data in the form of general efficacy and competency feedback.

Perhaps the most immediate benefit of a commitment to a comprehensive monitoring and evaluation system is that it forces the various components of the delivery system to look at the world together. Through the open sharing of information and the collective identification of issues, problems and solutions, jurisdictional boundaries become penetrable, differences become overt and relative contributions can be assessed and modified. By opening up the system to diverse sources of information along with the development of multi-variate designs, the stage is set for a re-examination of the traditional arena and the creation of new solutions to old problems. For this reason, we believe that the collaborative development of evaluation and information systems should be considered as a critical point of departure in preparing the way for a comprehensive approach to the delivery of mental health services to children and their families. It should become the focal point through which the involved parties begin by sharing their perceptions of what is and what might be.

At our level of discussion, we are not concerned with the specifics of particular monitoring or evaluation designs. Our primary concern is that the information generated and analyzed through such methodologies be made available to all parties directly or indirectly involved in the delivery of children's mental health services. As recipients of the system, they should also be encouraged to contribute directly by providing information or recommending changes in the system design. In accordance with our broader principles, we would argue in favour of a highly participatory system that would promote enlightened planning, efficient management, cost effective services, educated communities and knowledgeable consumers.

While we have accepted the need for information and evaluation systems as 'motherhood', we are also conscious of the potentials inherent in such technologies for generating organizational strain and dysfunction. A comprehensive model calls for the integration of these processes throughout the various levels of the service delivery structure where differential and conflicting needs or expectations prevail. In our design, for example, information provided to top level administrators regarding goal attainment around community mental health standards may present a very limited picture if measurements are focussed upon those outcomes that are the most readily measurable. This may

then be translated into pressures placed upon supervisors and practitioners to perform in ways that do not necessarily reflect either the needs of the clients or the principles of high quality professional practice. Hence, the information that empowers the administrator to act may also serve to undermine the autonomy of the practitioner. This may then result in profound conflict, strain and client neglect.

In the final analysis, information and evaluation systems should be directed toward the enhancement of the quality and effectiveness of direct services to the client. As Etzioni (1964) and Hasenfeld (1983) have suggested, however, effectiveness models may emphasize indicators that are more concerned with program efficiency due to the inherent difficulties involved in examining treatment processes, human characteristics and client change. Nevertheless a human service must be committed to placing the needs of the client and the skills of the practitioner at the centre of all evaluation aspirations. This means that the system as a whole should be prepared to examine both process and outcome variables that provide information to practitioners in a way that contributes to their skills and abilities in meeting the identified needs of their clients.

In conclusion, we would agree with the assertion of Grasso and Epstein (1986) that the primary issues in evaluation are not so much concerned with particular instruments or research strategies but the integration of measurement and the entire service delivery system. This means that the orientation, goals and dynamics of the system must be carefully considered in the development of all designs. As they suggest:

> At the very least, the systems designed must make sure that the measurement of effectiveness does not hinder the ability of the staff to improve their skill levels. At best measurement should promote professional development. Nonetheless, even the most sophisticated information system and computer technology will fail to produce beneficial effects without concurrent commitment to improving staff skill.

From our own perspective, we would take the process one step further to include the community as a primary participant and recipient in the process of information generation and dissemination. Obviously, there are numerous difficulties to be overcome in realizing this goal but it becomes absolutely essential if the ultimate objective is one of inviting these communities to assume increasing responsibility for the psychological wellbeing of their children.

David Burnett/Contact

PART II

MENTAL HEALTH SERVICES FOR CHILDREN, ADOLESCENTS AND THEIR FAMILIES IN THE PROVINCE OF ALBERTA.

INTRODUCTION

In this section of the document, we turn our attention specifically to the prospect of creating a systematic approach to the development of children's mental health services in the Province of Alberta. In our analysis of the provincial picture, we follow essentially the same format used in the previous section. The recommendations that make up the final part of this second section are not operationalized in detail. Given our experience with the project to date, it is our belief that all aspects of a strategic design should leave obvious room for negotiations rather than focus attention upon detailed aspects of the system. This task appropriately belongs to those who must ultimately assume responsibility for its implementation and operation.

Before addressing the Alberta picture, it may be useful to briefly review some of the main principles discussed in Section One:

1. Children and adolescents require a separate system of mental health services that addresses developmental needs.
2. Services should operate in support of the normative developmental, cultural, familial and community processes.
3. The focus should be upon mental health, rather than ill-health.
4. Mental health is a subjective experience, rather than an ascribed state.
5. Individual treatment is only one aspect of a comprehensive mental health system.
6. Treatment (as defined) should be the exclusive responsibility of the designated mental health service.
7. The overall objective is to enhance the psychological well-being of children and adolescents in accordance with an agreed upon set of community standards.
8. Service consumers should be 'empowered' with options and financial resources.
9. The system should operate in support of primary caregivers rather than assume this role.
10. Services should be based upon needs identified within the context of the community.
11. A high priority should be given to strategies of education and prevention.
12. The community should be viewed as a primary resource and the ultimate area of accountability.
13. The system should be negotiated with communities, service providers and jurisdictional planners in accordance with agreed upon principles.
14. Responsibility for establishing and maintaining standards should be clearly assigned to the mandated children's mental health jurisdiction.
15. Universality of access should be assured.
16. Adequate provision should be made for children and adolescents with special needs.
17. Native children and families should have access to the system in general with special provisions addressing cultural diversity.

1. THE ALBERTA PICTURE

Defining the Arena

At the present time, there is no coherent approach to the provision of mental health services for children, adolescents and their families in Alberta. The provincial government offers a range of assessment and treatment services through the Departments of Hospitals and Medical Care and Occupational Community Health as part of their general mental health mandates. The Department of Education provides some school-based services primarily focusing upon the identification and remediation of learning problems. More recently, the Department of the Solicitor General has begun to address the needs of children and adolescents subject to the provisions of the Young Offenders Act.

Traditionally, many of the young people in need of mental health services have been identified and assisted through programs operated and sponsored by the Department of Social Services. Although this jurisdiction has no formal mandate to provide professional mental health services, the acute and chronic needs of the clientele have made it necessary for such services to be made available. To fulfill this requirement, the Department has developed its own set of specialized resources through internal initiatives and outside contracts. Over the years, Social Services has developed the most comprehensive network of services dealing with 'troubled' young people and their families. Given the legal and ethical demands, there has been little choice.

Experience suggests that all of the above jurisdictions have struggled valiantly to meet the needs of those most in distress. With limited resources, no unifying philosophy or policy and little cross-jurisdictional co-ordination, however, the struggle appears to be endless. The resulting pressures are most significantly felt by those who are legally required to respond. Certainly there has been little opportunity to realistically consider the type of community-based preventative approach proposed in the first section of this document. Although there have been some initiatives in this direction, most of the work in this area has been left to advocacy organizations operating outside the service delivery network or conducted informally by allied professionals (e.g., public health nurses).

Identifying the Needs

With the constant pressure on service providers, there has been little incentive to look beyond the needs of those already on the doorstep. Epidemiological and prevalence data generally suggest that considerably more resources are needed to cope with the day-to-day demands of this population. Based upon traditional diagnostic criteria, however, even this group has not been clearly identified, being distributed across a range of service areas that do not usually collaborate in their research efforts. From the other side, community-based groups concerned with the mental health needs of children have neither the resources or the networks to accurately assess the needs identified or expressed in their particular region. More often than not, they must rely upon the opinions of the 'experts' or special interest groups to provide such information. To complicate matters further, there is no provincial policy or framework from which to determine what *is* a mental health need.

Current Strategies

Strategically, we have to conclude that existing mental health services for children, adolescents and their families in Alberta are almost exclusively directed towards those already experiencing significant distress. Since there is no coherent provincial approach, the stance is essentially reactive rather than proactive. The absence of any clear legal mandate makes it almost impossible for any jurisdiction or service delivery area to assume a position of leadership. As in most other parts of North

America, the strategy of not allocating resources specifically to the needs of children and families results in severe service deficits and considerable strain upon existing providers.

From our perspective, the current provincial strategy for addressing the mental health needs of young people places far too much emphasis upon the ability of a limited number of professional practitioners. By restricting mental health to issues of treatment, we isolate these professionals between the demands of jurisdictional planners and the communities they serve. While policy makers and planners attempt to carve out their particular segment of the territory, communities are often considered either incapable or incompetent in participating in the overall effort.

Certainly, the situation could be improved with massive injections of new resources into the system, but, in our view, this would not solve the problem in the long run. Given the issues raised in the first section of this paper, a more progressive step would be one of reformulating our entire strategy by providing the type of mandate that would enable a particular jurisdiction to take the lead in moving toward a more preventative community-based approach.

Resources

While we fully acknowledge that professional resources are generally in short supply, particularly in certain professions and service areas, without a clear mandate or assessment of need it becomes difficult to identify the particular deficits. In our review of existing and potential mental health resources in the province, we have concluded that the resource base may not be as inadequate as it first appears. Until these resources are clearly identified and grouped under the rubric of Children's Mental Health, however, they will continue to appear as flotsam and jetsam bobbing aimlessly in the turbulent waters.

We also believe that the most essential mental health resource — the community — remains largely unexplored. With little active encouragement, however, there are many individuals and groups in all regions of the province already committed to improving the psychological well-being of young people. Unfortunately, they are not usually perceived to be participants in the overall effort and their activities often serve to increase the pressures upon service planners and providers. Potentially, they offer support rather than a threat. In the long run, they may well be the vehicles through which communities will be able to assume increasing responsibility for their own mental health issues. This, in turn, would make it possible for mental health planners and practitioners to serve the community rather than the other way around.

Mobilizing Resources

In Alberta, as in most provinces and states, mental health services are planned at the top and delivered within the context of large bureaucratic structures. The mandates of the departments involved are unclear and there is generally no accepted philosophy, policy or standards to co-ordinate the effort. In Hospitals and Medical Care and in Community Health, resources are not mobilized within defined systems of children's mental health. In Social Services, Education and the Department of the Solicitor General, the commitment to mental health is generally perceived to be secondary to the major missions of the respective Departments. Even from this 'top down' perspective, there is no common agreement about the 'needs' toward which particular resources should be directed. While there are some mechanisms for inter-departmental communication, there is no single point of accountability to facilitate active co-ordination and co-operation.

In all of this, Alberta Mental Health Services remains relatively impotent with few resources to

spare for children's services, no compelling mandate to provide such services and relatively little experience in meeting the needs of troubled young people and their families.

One of the perennial issues is the reluctance on the part of the federal government to enter into cost-sharing agreements where the problems and services are labelled as "Mental Health". Hence, it makes more financial sense to look to those services where federal dollars are available. Without additional resources, however, Alberta Mental Health Services could not fulfill a legally prescribed children's services mandate without severely decimating services to adults. The prospect of 'claiming' resources from other jurisdictions represents a contentious option, particularly in a situation where there is no clear criteria for determining what a children's mental health resource actually looks like. On the other hand, there are undoubtedly many facilities and programs in the province that purport to address the mental health needs of children and adolescents in jurisdictions that have no formal mandate to offer such services. In many cases, these services are well integrated within their own service delivery systems and perform well in addressing the needs of their clients and it would probably be unwise to uproot them unless the advantages of an alternative system could be well substantiated.

As things stand, however, mental health resources for children, adolescents and their families are not systematically mobilized in the province. There is no unifying approach to service delivery. There are no commonly accepted standards from which to identify the resources in question and ensure an acceptable quality of service. Resources are distributed more in accordance with jurisdictional boundaries than regional equity and community need. Problems of co-ordination across these systems make it difficult for coherent planning to take place at both the policy/planning level and the direct service delivery end of the continuum. In these circumstances it is virtually impossible to apply the principles outlined in the first part of this paper.

2. STRATEGIC PLANNING RECOMMENDATIONS

Introduction

In the establishment of the Children's Mental Health Project, we set ourselves the task of designing a strategic plan for the delivery of a Children's Mental Health Service under the auspices of what was the Department of Social Services and Community Health. As indicated in our initial document, *Service Philosophy, Principles and Guidelines*, we had hoped to design a system of comprehensive services complete with its own organizational structure and linkages to other service jurisdictions. Through the course of the project we have become increasingly convinced that the creation and imposition of yet another system, however brilliantly conceived, would not achieve the goals of promoting inter-jurisdictional collaboration in developing services based upon the identified and expressed needs of children and families in Alberta. Rather, it is our belief that policy makers and planners should reconsider the entire domain of children's mental health in collaboration with the communities they seek to serve.

In this regard, we are of the opinion that Alberta Mental Health Services is in an ideal position to assume a leadership role. In the first place, there is no existing system to be protected. Secondly, this jurisdiction can be provided with a completely new mandate to create fresh initiatives rather than simply replicate more of the same. Thirdly, the division already has linkages with other government departments and community groups concerned with the issues of children's mental health. Finally, we would suggest that the preventative and community-based focus discussed in the first section of this paper is highly appropriate to the mission of the new Department of Occupational and Community Health.

From our perspective, a new system should not be planned from the top and imposed upon service providers, clients and communities. Even if it were possible for agreement to be reached at the inter-departmental level, the imposition of such a system would do little to enhance the causes of community participation and responsibility. The recommendations that follow are intended to create a provincial climate through which a system might emerge from the identified and expressed needs of communities, consumers and service providers. This 'grassroots' approach does not imply that we have cast organizational issues to the wind. Rather, we are proposing that, for the most part, things be held constant until we have a clearer picture of what the new system is aspiring to achieve.

The Mandate

In our view, the provision of mental health services for children, adolescents and their families necessitates the articulation of a clear legal and operational mandate. To ensure support and co-operation across government departments and jurisdictions, it is strongly suggested that a new mandate for Alberta Mental Health Services be fully discussed at the inter-departmental level and with major provincial service providers and interest groups. Ideally, these discussions should result in the generation of a joint policy statement on children's mental health. In this regard, we recommend that the following functions be considered within the mandate of Alberta Mental Health Services:

a. **The establishment of clear criteria and standards for the operation of children's mental health programs.** These standards should be developed in collaboration with other mandated jurisdictions and jointly monitored and enforced. Where such services exist in systems that have no mental health mandate, Alberta Mental Health Services should be responsible for accrediting and monitoring such programs.

b. **The provision of a wide range of educational, preventative, assessment and treatment services in each region of the province.** Alberta Mental Health Services should provide these services in all areas where needs are not being adequately met through other 'accredited' programs and jurisdictions. These might be accomplished through direct service delivery or contracting services to other parts of the system. The identification of these service areas should not be established on an a priori basis, however. Rather, they should be determined in response to the needs of service providers and communities. The essential principle is that all children's mental health services (as defined in the first part of this document) should be fully accredited and operate within one of the jurisdictions carrying an appropriate mandate.

c. **The establishment of a clear mandate to initiate, co-ordinate, monitor and operate educational and preventative community-based strategies.** We firmly believe that a commitment to prevention should be part of the mandated responsibility of Alberta Mental Health Services. Clearly, this implies that resources should be specifically allocated to this area.

d. **The establishment of cross-jurisdictional mechanisms for communication, collaboration and co-ordination.** In this area, it is recommended that Alberta Mental Health Services be mandated to create new mechanisms for provincial collaboration in the arena of children's mental health. In this regard, existing inter-departmental initiatives should be formalized and expanded to include other provincial groups involved in the provision of services to children and families. The overall purpose of this process would be to generate joint statements of policy, ongoing assessments of needs and recommendations regarding modifications in the systems of service delivery. As part of this responsibility, we also recommend that information and research systems be established to serve all communities and jurisdictions.

e. **The establishment of effective mechanisms for community involvement and participation.** We recommend that Alberta Mental Health Services be given a clear mandate to bring the community into the arena of children's mental health planning and service delivery. While the basic principles of this approach are, to some extent, exemplified by existing Regional Mental Health Councils, it is suggested that this does not go far enough to ensure representative community participation. In our view, the system should be supplemented by community boards established to advise, monitor and, in some cases administer, as integral components of the system. We also believe that the nature and organization of these mechanisms should be largely regionally determined.

f. **Ultimate responsibility for ensuring that the mental health needs of children, adolescents and families are being adequately addressed in each region of the province.** While we recognize the enormity of this task, we firmly believe that this responsibility must be located somewhere within the system until such time as the communities themselves can begin to assume increased accountability. Since no one jurisdiction effectively controls all the resources that make up the 'system', the strategy must necessarily be one of negotiation and collaboration. In the final analysis, it would be necessary for the responsible jurisdiction to have the resources required to ensure the maintenance of established standards and make up deficits through direct service provision. In our opinion, Alberta Mental Health Services is in the best position to assume this role.

Strategies

a. **Joint Policy and Planning.** Strategically, it is recommended that Alberta Mental Health Services take the initiative in setting up a process for joint policy making and planning at the provincial level. In our view, this process should not be restricted to representatives from the various governmental jurisdictions but extended to include advisory, advocacy and service groups that assume a provincial perspective. Initially the issues to be addressed would include:

- — An acceptable policy statement on children's mental health services.
- — The identification of jurisdictions mandated to provide children's mental health services.
- — The roles and responsibilities of the mandated jurisdictions.
- — The relationship between these jurisdictions.
- — The provision of mental health services to non-mandated jurisdictions.
- — The relationship between Alberta Mental Health Services and mental health programs operating in non-mandated jurisdictions.
- — Jurisdictional responsibilities in the monitoring and maintenance of standards.
- — The development of standards for accreditation.
- — The establishment of research and information systems.
- — The areas of direct service delivery to be assumed by Alberta Mental Health Services.

b. **Developing a Legal and Operational Mandate for Alberta Mental Health Services.** The details of the legal and operational mandate for Alberta Mental Health Services should be articulated in the light of joint policy and planning and the needs identified through community and service delivery involvement. While this might be a topic for ongoing discussion and consultation, it does not mean that the broad parameters of such a mandate cannot be established quickly. In our view, some functions are self-evident. These include:

- — The establishment of standards for service delivery.
- — The accreditation, monitoring and 'supervision' of mental health programs operating outside mandated jurisdictions.
- — The direct provision of services for children, adolescents and their families in each region.
- — The operation and/or supervision of all secure treatment programs.
- — The provision of mental health services to the Department of Social Services and the Solicitor General.
- — The development of provincial and regional strategies for education and prevention in the area of children's mental health.
- — The establishment of research and information systems.
- — The creation of legislation specifically addressing mental health services for children, adolescents and their families.

c. **Establishing a clearly differentiated component for children's mental health services at both the provincial and regonal levels.** In this regard, we recommend that a provincial Director of Children's Mental Health be assigned immediately, accountable to the Associate Director of Mental Health Services. The role description should be in accordance with the broadly defined mandate and the necessary

resources be made available. By the same token, a Co-ordinator of Children's Mental Health Services should be appointed in each region of the province accountable to the Regional Director of Mental Health Services. Resources should then be allocated on the basis of each particular regional plan.

d. **Establishing information centres in each region of the province.** In many ways, we view this strategy as the most critical point of departure in developing a children's mental health system that reflects the needs of the communities. These centres would serve as one-stop sources providing any member of the community with information about the availability of children's mental health services within their particular region. At the same time, they would provide ongoing information back to the system regarding community needs and expectations. Staffed by professionals drawn from the major service delivery jurisdictions, they would provide the consumer with options, while promoting face-to-face collaboration across service delivery areas. From a broader perspective, we believe that such centres could become effective vehicles through which communities could 'speak back' to the systems that serve them.

In order to be effective, it would be necessary for these proposed centres to avoid the temptation of becoming involved in treatment or direct service delivery. While it might be necessary to have one 'emergency' clinician available, the essential purpose would be to provide a communication link between the communities and the system at large. This would involve some standardized assessment procedure but, again, the temptation to provide specialized assessments would need to be avoided.

The information generated through such centres would not necessarily be restricted to that provided by consumers, or potential consumers. Ideally, they could become the hub of community activity in addressing the broad mental health needs of children and families. In our vision they could be used by the community to educate and promote the cause of children's mental health in an infinite variety of ways. For this reason, we believe that the operation of such centres should be the responsibility of some form of community board, such as the Regional Mental Health Council. In this way, they would operate independently and not be perceived to be just another component of the bureaucracy.

Clearly, the concept of the community information centre exemplifies our particular orientation to children's mental health. Effectively operated such centres would empower communities, facilitate inter-professional and cross-jurisdictional co-operation and sensitize service providers to community needs. With particular reference to the task of the Children's Mental Health Project, we believe that such centres could generate the essential community-based information from which a comprehensive and co-ordinated spectrum of children's mental health services might evolve. They should be considered as community-based research facilities and resourced accordingly.

e. **Negotiating the delivery of children's mental health services with the Department of Social Services.** We believe that the relationship between Alberta Mental Health Services and the Department of Social Services represents a critical aspect of services to children and families. From the broadest perspective, we see Alberta Mental Health providing a variety of specialized functions for the Department of Social Services. These include:

— Assuming responsibility for the operation of mental health programs.

— Providing accreditation and supervision for mental health programs.

— Providing direct services to Social Service clients.

— Providing consultative services to Social Service personnel.

— Providing joint screening and assessment services for clients.

In addition to these types of contractual arrangements, we also believe that the relationship should be highly collaborative in direct service delivery. In this regard, we continue to advocate for the type of case management system outlined in our initial discussion paper, *Service Philosophy, Principles and Guidelines*. The implementation of such a system, however, requires considerable discussion and negotiation and we would urge the two jurisdictions to establish the necessary mechanisms immediately.

f. **Develop a strategy for serving Native peoples.** As we suggested in the main body of this document, the provision of mental health services to Native children and families requires separate provincial and regional strategies. For this reason the Children's Mental Health Project is developing a separate document to address this issue.

Essentially we take the position that we should begin by involving Native people at the conceptual stage and that strategic plans should be differentially tailored to the needs and wishes of the various groups and communities across the Province. In this regard we should expect to move in a variety of different directions, at different rates. We should be prepared to challenge our theoretical perspectives and traditional practices in supporting Native initiatives while ensuring that all mental health services are available on a universal basis. We must be prepared to learn.

In order to achieve this, we recommend that a Provincial planning group be established immediately with linkages to similar regional groups. We should move immediately in support of existing initiatives such as that developed by the Peigan Nation in the Southern Region while operating on the general principle that "nothing is written in stone".

3. A FINAL WORD

At the time of publication, there are many individuals and groups in the Province of Alberta actively involved in the planning and development of mental health services for children and adolescents. Their commitment, creativity and competence generate considerable hope for the future. It is our hope that this document will serve to support and encourage their efforts whether they choose to accept or reject the premises and proposals contained in the preceeding pages. Their task is monumental and it is unlikely that they will ever receive the recognition they deserve for caring enough to push new edges and taking the risk to become accountable for their practices and beliefs. There are no absolute truths and no universal answers.

In developing this consultation document, we have tried to maintain a sense of fidelity to our own practices and beliefs. In so doing, we leave ourselves open to challenge from many diverse and fascinating sources. We fully anticipate accusations of naivete, idealism, unprofessionalism and distortion. There will be those who regard the paper as being overly general while others will readily immerse themselves in the polemics of detail. Then, of course, there will be those who simply dismiss our efforts as inconsequential, given the relative strength of their own positions and their power to influence future events. All of these challenges are, in their own way, valid. It is unlikely that we will change such opinions and beliefs. On the other hand, we must also be prepared to have our intentions called into question and this we consider to be a horse of a different colour. In response to such a challenge, we can only reaffirm that we consider the ideas expressed in these pages to be in the best interest of children and young people.

Finally, we would like to express the hope that the issue of children's mental health in the Province of Alberta will not be restricted to esoteric discussions involving a limited number of individuals and groups already participating in the arena. Our desire is to expand the circle . . . immediately.

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